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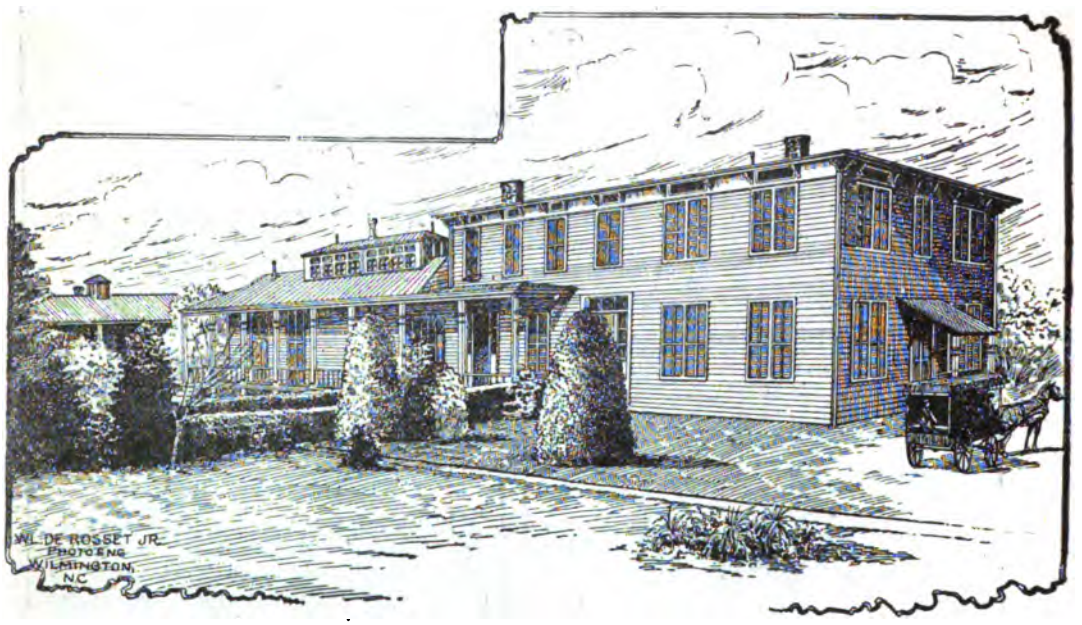

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LAPARO-HYSTERECTOMY FOR EPITHELIOMA, WITH RECOVERY.

BY CORNELIUS KOLLOCK, A.M., M.D., Cheraw, S. C.

[*Written expressly for this Journal.*]

It is more than probable that complete removal of the uterus was practised by the ancient Greeks. It is also very certain that, if so, the operation subsequently fell into disuse, and almost passed from the memory of man, until Soranos of Ephesus spoke of it in a work written about a century before Christ. We hear nothing positive, however, of hysterectomy till 1560, when Andreas a Crucé is said to have done it successfully. In 1813 Langenbeck removed the entire uterus. Some doubted the truth of his report of the case, but at the death of the woman, thirty years after, an autopsy proved positively that the uterus had been removed. From 1829 to 1839 Blundell, Recamier, Siebold, Dilbeck and others recorded cases, but most of these being failures, the operation was discountenanced until 1879, when Czerny, interested in the report of Langenbeck's case, revived it with considerable success. Billroth, Mikulioz, Schroeder, Condereau, Hennig, Freund and others soon practised it, and it is now recognized as a proper surgical procedure.

Objections have been urged against hysterectomy for epithelioma on account of the liability of the latter to return. But the same objections hold good against all operations for malignant disease. It is a fact well established that when the seat of a malignant disease is an organ well isolated, so that the whole of the affected part can be removed, the chances of return are much less than when the whole affected part cannot be taken away. This is especially true in regard to epithelioma. Scirrhus, carcinoma and sarcoma are far more apt to be reproduced than epithelioma, after the removal of the whole

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diseased part. It is a little singular that a microscopic examination reveals the fact that the cells in epithelioma are very like those in scirrhus or carcinoma. Yet there is certainly not the inveterate infiltration in epithelioma that there is in other malignant diseases. It does not seem to be so deeply constitutionally imbedded. Scirrhus and carcinoma, however isolated the part from which they have been removed, are, in the large majority of cases, sooner or later, reproduced. Not so with epithelioma, an operation for which, while it may not entirely eradicate it, contributes materially to the comfort of the patient, and greatly prolongs life. Another fact which seems to prove that epithelioma is not so thoroughly constitutional as scirrhus or carcinoma is that, if it returns after removal, it is always on the original site. Not so with these orher malignant affections. It is impossible to predict with any accuracy the time or spot at which they will be reproduced. A scirrhus or carcinoma removed from the mammary gland, may reappear in the same place, or on some internal organ. I removed a scirrhus tumor from the breast of a patient; the incision healed finely by first intention, and the parts seemed to be perfectly healthy. In six months time she was greatly annoyed by pain in the stomach and constant nausea. This increased until life became a burden. She died of starvation, being for weeks unable to take any nourishment. An examination showed the formation of a scirrhus at the cardiac orifice of the stomach. It is true that epitheliomatous growths will sometimes be reproduced after having been apparently thoroughly removed, but, in the majority of instances, it is after an operation has been delayed too long—when, by thorough infiltration, adjacent tissues have become contaminated. I have removed a number of such growths, and have never known one to return, when situated on a part completely isolated, unless it was in a case of long standing.

In my humble opinion, when epithelioma attacks the uterus at any point, to secure a complete eradication of the disease, the whole organ should be removed, whether the disease pervades the entire uterine structure, or only a part is invaded. It often affects only the vaginal cervix—sometimes extends into the cervical canal—and again reaches the extreme limit of the fundus. Often, when the disease seems to be circumscribed, other parts apparently sound may be so tainted that it may manifest itself in them at some future time. Fritsch, who has been thoroughly identified with this view, and who has had a large experience in the operation, contends that, in all cases, even when the disease is confined to the cervix, the whole uterus should be removed. It prevents a reproduction of the growths, and spares the patient the pain consequent upon menstruation when only a portion of the organ has been taken away.

A remarkable fact, and one worthy of consideration, is that total extirpation of the uterus is an easier and less bloody operation than a cervical, or a high, amputation.

Fritsch's position has been strengthened by Schauta of Prague, who says that, two years after the operation, 100 per cent. of those who had undergone the radical one were free from the disease, while only 40 per cent. of those who had submitted to the partial one had recovered.

A case that occurred, not a great while ago, in my own practice, I think clearly illustrates the position above assumed. Mrs. R. H. B., aged 34, had had four children and two miscarriages. Her health was apparently good until 1888, when menstruation became too frequent and too free—sometimes came on every two weeks—and was always

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accompanied by considerable pain. This increased so rapidly in severity that she resorted to opiates for relief. She soon got up to twenty grains of morphia daily. This had been going on for four or five months when I first saw her, on the 12th of September, 1888. The discharge then, at every menstrual period, was equal to a post-partum hemorrhage. She was confined to her bed fifteen days in every month, was so exhausted by pain and loss of blood as to become anæmic. Her complexion was like white wax—perfectly colorless. There was also slight œdema of the upper and lower extremities, and a puffiness about the cheeks and eyes. Hers was undoubtedly a case of epithelioma of the uterus, but the disease had extended only a short distance above the internal os. None was visible at the external os, though, of course, it must have invaded the cervical canal; nor was there any positive evidence, so far as could be ascertained, that the internal cavity was affected much. There were no apparent adhesions of the uterus or its appendages to anything in the cavity. Her condition being such as above described, I hesitated about attempting an operation. But she had made up her mind to it, and piteously begged to have it done. Feeling assured that nothing else would give her any chance of recovery, or even prolong her existence, I decided to undertake it.

Freund's operation for complete extirpation of the uterus, by incision through the abdominal walls, was the method fixed upon. With many this has been objected to, on account of the position in which the patient must be placed—the same as that in common laparotomy—and for this reason it, for a time, fell into disuse. But this objection has been obviated by the Trendelenburg posture. Not being willing to attempt the operation by the vaginal method, I did it through the abdominal cavity. Opening the abdomen by an incision three and a half inches below the umbilicus, I found the fundus resting on the back part of the pelvis, a little removed from the bladder. With hooks, the fundus was drawn as near as possible to the incision in the abdomen; I then passed with an aneurism needle a silk ligature including the ovarian artery and as much as possible of the broad ligament; a second ligature was then passed including what remained of the broad ligament and the uterine artery. The vessels on the opposite side were secured in the same way. I then dissected away, both behind and in front, as much peritoneal investment as was possible or proper. Then a cross cut was made below the junction of the cervix into the vagina, and the uterus was quickly removed. It being the opinion of many standard writers—and also my own—that the disease is more likely to be reproduced if the ovaries and tubes be left in, I removed them. The operation was accompanied by very slight hemorrhage, for the ends of the vessels when cut were all held by compression forceps. A large piece of gauze was spread over the intestines, at the extreme upper end of the abdominal incision, to protect the cavity from any fluid, or blood, which might collect in the uterine pouch posteriorly. The toilet of the peritoneum, by this method, was very simple and easily made. The peritoneum was closed by a continuous catgut suture holding one peritoneal surface against the other. This prevented the possibility of any infection traversing the vagina into the abdominal cavity. A straight glass drainage tube, of medium size, was kept in for two days.

I think the entire success of this operation depends upon securing the arteries in the broad ligament before the removal of the uterus, dissecting from the posterior and anterior walls of the uterus a generous slice of peritoneal

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investment, so that the vaginal abdominal wound may be completely closed. When this is done there is no danger of hemorrhage or infection.

The patient had a fine and rapid recovery—was up and about her room three weeks after the operation. She is now in apparently perfect health—has gained thirty-six pounds in weight. For the first six months after the operation there was, at the return of each menstrual period, considerable commotion in the pelvic region, accompanied by some pain in the back and fulness in the head. This grew less and less every month, and finally passed entirely away.

CASE OF PUERPERAL SEPTICÆMIA.

By F. Peyre Porcher, M.D., Charleston, S. C.

[*Written expressly for this Journal.*]

We report this case on account of its great severity and the desperate extremity to which the patient was reduced.

Mrs. M., primipara, aged 22, had an abortion, June 10th, 1892, with the delivery, after a labor of fifteen hours, of twins, five months, feet presentation, one fetus swollen and partially decomposed, the other in fair state. There was great difficulty in extracting the head of the one delivered last, which was grasped by the neck of the uterus, and force was required to slowly dilate the contracted os; this, doubtless, was the source of the subsequent difficulty. The placenta came away spontaneously, there was no hæmorrhage, the lochia were very scanty. Notwithstanding the absence of symptoms of uneasiness, for days the vagina was injected, bis die, with bichloride solution, 1 to 4,000, and carbolic acid solution, 3 j, to a pint of hot water.

On the morning of the 15th, in the midst of apparent calm, without known cause or imprudence, patient had an extremely violent chill of long duration, followed by a burning fever, great distress, face purple, vagina excessively hot and dry, lochia suppressed, with severe vomiting and purging; temperature not recorded.

The several measures adopted were as follows: Use of ice and cold sponging of head, hands and arms, an hypodermic of morphia, gr. ¼, and atropia, gr. 1-100, with the following as an ideal prescription for such a condition:

℞—Morphia.....gr. ii.
Ess. peppermint..... ʒ ii.
Sp. turpentine..... ʒ ii.
Oil of eucalyptus..... ♏ xx.
Chlorate of potash..... ʒ i.
Quinine.....gr. xx.
Alcohol..... ℥ i.
Gum water, to..... ℥ iv.

M. S.—Dessert spoonful every two hours. Hot carbolized water, with a solution of Marchand's peroxide of hydrogen, four tablespoonsful to every pint of water, used alternately, were injected into the womb t.i.d., through a female catheter attached to the nozzle of a Davidson syringe.

She suffered greatly from distension, which was relieved by poultices made with fresh mint, steeped in boiling whiskey, with soda and mint internally; also repeated applications of hot turpentine stupes.

In forty-eight hours the temperature was reduced to 100°, pulse 100; but there was an extremely severe herpetic eruption (fever blister) surrounding the

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mouth and lips, the mouth being so much inflamed that she could swallow with difficulty. This was relieved by an application of lead cerate, ℥ ss., aristol, gr. x, subnitrate bismuth, ʒ ss., which proved extremely soothing and curative.

On the 19th, being materially better, the mixture was discontinued, and quinine, gr. vi, t.i.d., and hot carbolized water and milk and hot water vaginal injections were employed. She took milk punch and brandy and water throughout the course of her illness, and 1-30 of a grain of strychnia at night for two or three nights.

Her temperature varied after the initial attack from 103° to 100°, never over 103°. That a dangerous fever, following a chill of great severity, should be reduced by the treatment—the antiseptic irrigations, milk injections, cold applications, etc.—as described, is very satisfactory; but it will be remarked here that mere temperature is not an indication of the severity or danger to life of a disease, for simultaneously with this case a Mrs. B., recovering from an attack of acute dysentery, for two days had a continuous temperature of 104°, which descended to 99°, and left her only a little weak.

Attendance was discontinued on the 20th, temperature 98¾°, having used the vaginal irrigations continuously, with quinine; found phenacetine, gr. v, very serviceable at night to lessen temperature and promote sleep. Ice was craved and swallowed throughout on account of the general erethism of the mucus surfaces, as indicated by the eruption of the lips and mouth, referred to above, and she could take nothing unless it was preceded by bits of ice.

A few words with regard to the formula above mentioned: After using it for some hours—its effects being extremely soothing and agreeable—it became a question of great moment whether the morphia might not prove injurious by masking symptoms of pain, etc.; and on account of the doubt the following fever mixture, containing aconite, was substituted:

℞—Bromide of potash.... ʒ iss.
Tinct. of aconite.....gtt. l.
Spiritus mindererus... ℥ i.
Chlorate of potash.... ʒ iss.
Ess. peppermint..... ʒ i.
Chloral..... ʒ i.
Camphor water, ad.... ℥ iv.

S. Dessert-spoonful every two hours in a little water.

Professor T. G. Thomas, of New York, whose opinion was obtained, without pronouncing upon the relative claim of the morphia and aconite, replied that he thought the ideal mixture was admirable, but not to omit "to pursue the bacillus in its lair." It will be noticed that there had been no neglect in this particular.

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CONSOLIDATED STATEMENT OF THE MORTALITY OCCASIONED IN NEW ORLEANS, LA., BY FEVERS (YELLOW FEVER, TYPHOID, TYPHUS AND MALARIAL FEVER), AND OTHER GRAVE FORMS OF DISEASE, (PHTHISIS PULMONALIS, ASIATIC CHOLERA AND BOWEL AFFECTIONS), DURING A SERIES OF YEARS.

By Joseph Jones, M.D., LL.D., Professor of Chemistry and Clinical Medicine Tulane University of Louisiana, Visiting Physician Charity Hospital.

[*Written expressly for this Journal.*]

It is of importance that the actual and relative mortality occasioned by various diseases in different cities and localities should be accurately recorded.

In such statistics the practitioner of medicine and the sanitarian will find many important facts and much food for reflection.

The Destructive Effects Occasioned by Yellow Fever and the more Fatal Diseases in New Orleans, Louisiana.

The relative position held by yellow fever with reference to the importance and fatality of various diseases, will be illustrated by the following table:

Total Number of Cases and Deaths of the Various Forms of Fever Treated in the Charity Hospital of New Orleans during a Period of 34 Years—1847–1880.

Diseases.	Cases.	Deaths.	P. Ct.
Yellow fever	19,233	9,667	52.2
Typhus fever	7,222	1,303	18.0
Typhoid fever	3,521	1,163	38.0
Dengue fever	636	0,000	00.0
Nervous fever	51	13	25.4
Adynamic or ataxic fever	27	4	14.9
Ephemeral fever,	563	0,000	00.0
Continued fever.	1,099	88	8.0
Catarrhal fever	111	1	0.8
Gastric fever	113	3	2.7
Remittent fever.	15,361	311	2.0
Intermi'nt fever.	75,670	128	0.1
Congestive fever.	1,218	699	57.3
Pernicious fever.	478	320	66.9
Malarial fever	6,251	636	10.1
Malarial pois'ing.	431	50	11.6
Malarial cachexia	95	8	8.7
Typho-malarial fever	117	66	47.8
Other forms	135	20	14.8
Totals	304,213	43,718	14.3

During a period of 34 years—1847–1880—19,233 cases of yellow fever were treated in the Charity Hospital of New Orleans, of which 9,667, or 50.2 per cent. terminated fatally. During the same period, including yellow fever, 132,322 cases, with 15,480 deaths of the various forms of fever, were treated in the Charity Hospital.

If the cost of treatment of each case to the State be placed at the low figure of $20, then Louisiana expended during these 34 years $2,646,700 for the treatment of fevers alone.

Whilst yellow fever numbered only 19,233 cases out of a grand total of 304,213 cases of all fevers, it caused 9,667 deaths out of a total of 43,718 deaths from all fevers during 34 years in the Charity Hospital of New Orleans.

Deaths from the Various Forms of Fever in the City of New Orleans during a Period of 34 Years—1847–1880.

Diseases.	Deaths During 34 Years—1847–'80.
Small-pox and varioloid	5,726
Measles	1,589
Scarlatina	2,066
Dengue	21
Typhus fever	1,422
Cerebro-spinal fever	371
Enteric or typhoid	3,720
Simple continued fever	407
Yellow fever	28,739
Gastric fever	19
Malarial fever	— —
" " intermittent,	921
" " remittent	1,299
" " congestive	6,337
" " typho-mala'l,	93
Malarial unclassified	3,747
Total	56,478

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During a period of 34 years—1844–1880—the following diseases caused the number of deaths specified in New Orleans:

Diseases.	Deaths During 34 Years.
Cholera	11,847
Cholera morbus	887
Cholera infantum	2,408
Total	15,144
Enteritis	6,915
Diarrhœa	8,289
Dysentery	7,097
Total	22,301

Deaths from phthisis pulmonalis in New Orleans during 34 years—1847–1880—24,071.

Total deaths in New Orleans during 34 years—1847–1880—from all causes, 242,426.

While fevers of all varities destroyed in the City of New Orleans 56,478 citizens in 34 years, yellow fever destroyed only one-half of this number, namely, 28,739.

If these fevers be divided into separate groups, the mortality will stand thus:

Total deaths from small-pox, measles and scarlet fever during 34 years, 9,381.

Total deaths from dengue, typhus fever, cerebro-spinal fever and simple continued fever, 5,942.

Total deaths from yellow fever, 28,739.

Total deaths from various forms of malarial fever, 12,413.

The deaths from the various fevers and malarial fever, indigenous to the soil or common to all parts of the great Valley of the Mississippi, were very nearly half as numerous as those caused by yellow fever, congestive fever alone causing 6,337 deaths.

It is well established by the records of medicine extending back over 2,000 years, that drainage and agriculture are the great and only absolute and certain means of destroying the cause of malarial fever.

If the value of a citizen of the United States be estimated at $1,000, then the City of New Orleans has lost during 34 years $56,478,000 by fevers alone; other diseases, however, whose existence and propagation are largely dependent upon defective drainage, have been busy in this work of destruction. Thus, during the 34 years specified, phthisis pulmonalis destroyed nearly as many citizens as yellow fever, namely, 24,071; enteritis, dysentery and diarrhœa, 22,301, and cholera, cholera morbus and cholera infantum 15,144—total from phthisis and bowel affections, 67,616 deaths.

Those diseases which are common to the entire Valley caused 67,616 deaths, exceeding those by fevers 5,138.

Without doubt a very large proportion of the deaths from phthisis pulmonalis and bowel affections are preventable and directly referable to defective drainage. Fevers, general affections and phthisis pulmonalis alone caused New Orleans 118,094 deaths in 34 years, and of a total of deaths, from all causes, of 242,426.

We may therefore affirm that nearly one-half the deaths in New Orleans, during the past 34 years (118,094) were caused by preventable diseases, the important sanitary measure for the diminution of the same being *effective drainage.*

From these diseases New Orleans has lost, in 34 years, $118,094,000.

No city in the world has suffered more obloquy than New Orleans in reputation for health, and more especially in regard to its epidemics of yellow fever.

If, by the application of all the facts known to science, the sanitary condition of New Orleans can be so improved as to exclude yellow fever, or to arrest its first beginnings, it is not unreasonable to believe, when we consider the extent and extraordinary fertility of the basins of the Mississippi and the Missouri, that New Orleans is destined to become the greatest emporium, not of America only, but of the world.

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Measures for the Prevention and Arrest of Yellow Fever.

The measures for the prevention, exclusion and arrest of yellow fever may be divided into three divisions:

1. Local sanitation.

2. Sanitation of all public conveyances, including ships and railroads.

3. Quarantine, embracing inspection, detention and thorough disinfection.

The absence of yellow fever from New Orleans during 1880, 1881, 1882, 1883 to 1892, would support the theory that this disease is not indigenous to New Orleans.

If yellow fever be not indigenous to New Orleans, its exclusion depends upon a rigid quarantine.

When introduced the health authorities should be provided with sufficient men and means to combat the disease, and to thoroughly disinfect and cleanse any focus of disease, as was successfully done in 1882, under the direction of the author (then President of the Board of Health of the State of Louisiana), in the third district of New Orleans, in the cases of Forbes, Strot and Englund.

The great difficulty rests in the prompt recognition and immediate report of the first case or cases. Correct diagnosis is of infinite importance.

156 Washington Ave.

THE TREATMENT OF SALPINGITIS BY DEPLETION AND DRAINAGE SECURED BY ELECTRICITY.

Abstract of the paper by Dr. Augustin H. Goelet, of New York, read before the Second Annual Meeting of the American Electro-Therapeutic Association held in New York, October 4th, 5th and 6th.

The author stated that he had recently reported at the New York Obstetrical Society a number of cases treated successfully by this method, but some of the members were inclined to doubt the part played by electricity in producing the results, and objections were made to electro-therapeutics in general on the ground that it was made mysterious and complicated. They endeavored to explain the results obtained by supposing that they were due to rest in bed and the time consumed in the treatment. In reply to these criticisms, the author said that the patients were not confined to bed, and the treatment was instituted after protracted efforts by other methods in the hands of other specialists and after laparotomy had been advised.

He thought that if those gentlemen who found so much mysticism surrounding the subject would study electricity, learn the principle of its action, and take the trouble to understand it, the mysticism would disappear. One gentleman thought hot water would do all that had been claimed by the author for electricity, and that it would relieve pain as promptly, in spite of the fact that, in the cases reported, all the usual remedies, including hot water, had been tried without marked benefit.

Dr. Goelet was not inclined to deny the value of hot water and other time-honored measures, nor question their usefulness; but that they at times fail, are slow in their action, and are limited in their usefulness, he thought would not be denied.

The author contended that the principles involved in the electrical treatment were the same as in the other measures usually adopted for the treatment of these conditions, namely, deple-

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tion and drainage, and with perhaps stimulation of the lymphatics to promote absorption. But he did not believe, as some had contended, that counter-irritation entered into the action of the electrical treatment. He was inclined to favor the method of dilatation, curettement and drainage with gauze in certain conditions, but thought its usefulness was limited, and electricity could be employed in conditions where this would not be appropriate. He was inclined to believe that electricity was not more universally employed because its value was not appreciated, and less pains was taken to better understand it, and in consequence it was regarded as mysterious, and its results were discredited, because it was considered too intricate to be clearly appreciated without some thought and study.

The author explained his preference for electricity in these conditions by saying that after an experience of fifteen years with the older methods of treatment, he had found them tedious, slow and exceedingly unsatisfactory, and was willing to welcome any plan which promised more satisfactory and prompt results, and which saved the patient from a mutilating operation, the results of which are, by no means, always what could be desired. He frankly confessed that the method of treatment advocated by him had given both him and his patients more satisfaction than any other, and he believed that the more one used it, the better they knew how to use it and the better the results. He would not, however, contend that this particular method was appropriate in all conditions, nor should it be used always to the exclusion of other remedies, and declared that he had used the method suggested by Dr. Polk and others with satisfaction in suitable cases.

The author thought it would hardly seem necessary to say that, in order to obtain satisfactory results with this or any other therapeutic measure, it should be used intelligently and with a definite purpose in view; yet electricity is frequently used in a haphazard manner by men who wonder why they do not succeed; and their failures cause them to discredit the value of the agent. He regarded two things essential for success, namely, first, an accurate diagnosis of the existing condition with the indications for treatment; and second, the employment of the agent for a definite purpose, and in a manner to meet the indications. He employs the galvanic current for the purpose of effecting relaxation and dilatation of the cervical canal with drainage from the uterine cavity, which is accomplished by using the negative pole attached to a metallic electrode placed in the canal. A moderate strength of current is employed, when dilatation without cauterization is desired; but an increased strength is necessary when destruction of the diseased endometrium is required. Profuse drainage, resulting in depletion, follows the use of this pole employed in this manner, and relaxation with dilatation of the lumen of the Fallopian tubes when they are obstructed by tumefaction of the mucous lining, likewise results from the use of this pole in the uterus. He quoted Bland Sutton as saying that the uterine end of the tube is rarely occluded in salpingitis, but the obstruction is due to tumefaction of the mucous lining, hence drainage in this direction is possible upon subsidence of this tumefaction. The same authority declares that the tender pelvic swellings found in these conditions are in many instances the Fallopian tubes swollen in consequence of the catarrhal condition of the mucous membrane, and that the swelling, pain and tenderness vanish with the subsidence of the inflammation.

Dr. Goelet thought that the accomplishment of this result here should not be considered unreasonable when it is

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possible in other localities. For this purpose he was in the habit of employing both the galvanic current, as above described, and the faradic current, also, for the relief of the associated pain and congestion. The intra-uterine applications likewise effect a cure of the endometritis, which, in all probability, was the origin of the tubal inflammation, and is directly responsible for its continuance. He thought the positive pole was contra-indicated if there was any pus accumulation, or if there was insufficient drainage from the tube, but employed it in the absence of these contra-indications to aid the removal of tumefaction and congestion, employing the vagino-abdominal method by preference.

In commencing the treatment of these cases, he prefers to employ the faradic current of tension—first, to quiet the pain and render the patient comfortable, for which purpose he utilizes the bi-polar method in the vagina; later he continues the use of the faradic applications to the vagina for the purpose of stimulating peristaltic movements of the tubes which favor evacuation. He drew attention to the fact that, in order to obtain the desired effect from the faradic current, it was essential to utilize reliable apparatus, otherwise failure, rather than success, would follow its use.

In conclusion, he remarked that the chief indications in the treatment of these conditions was to relieve the pain, relieve the engorgement and tumefaction and to secure drainage from the uterine cavity and the tubes, and he believed that electricity, if properly employed, could be depended upon to accomplish these results.

THE TREATMENT AND MANAGEMENT OF ASTHMA.

An Abstract of a Lecture delivered to the Class in the Philadelphia Polyclinic, November, 1892, by Thomas J. Mays, M.D., Professor of Diseases of the Chest in the Philadelphia Polyclinic and Visiting Physician to the Rush Hospital for Consumption, of Philadelphia.

Asthma is a paroxysmal disease of the pneumogastric nerves, which throws the muscular fibres of the bronchial tubes into spasmodic contraction. Its prominent symptoms are itching of the head and neck, oppression and tightness of the chest, dyspnœa, bloating of the abdomen and pain in the region of the diaphragm, cough, expectoration and fever. Its causes are predisposing and exciting. (1) It may be inherited as asthma, and it may appear in children who come from consumptive or nervous families. It seems as if there is a predisposition necessary before the disease can develope. (2) Among the exciting causes are the inhalation of dust, powdered ipecacuanha, pollen of grasses and of roses, odors of certain animals, as cats, sheep, etc., etc.—reflex excitation coming from the nose, stomach, liver, intestines, uterus, etc. Its relation to hay fever is very close; practically there is no difference between the two; I find that that which relieves the one will also relieve the other.

Its treatment resolves itself into that (1) which aims to give immediate relief from the paroxysm, and (2) that which aims to prevent a recurrence of the paroxysm. Those remedies which relieve the paroxysm may be classified as follows: (1) central narcotics, consisting of morphine, belladonna, stramonium, hyoscyamus, tobacco, chloroform, ether, ethyl bromide, ipecacuanha, sanguinaria, etc., and (3) the peripheral narcotics, relaxants, consisting of nitro-glycerine,

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amyl nitrite, sodium nitrite, pilocarpine, etc. Now, all our more or less powerful therapeutic agents are stimulants to the general or special body tissue which they affect, in small doses, while in large doses they paralyze the same. All the above-named agents only relieve asthma when given in large or paralyzing doses, the central narcotics exerting their influence on the central nervous system, the emetics acting on the pneumogastric filaments, while the peripheral narcotics paralyze the vaso-motor or sympathetic nerves, which supply the unstriped muscular fibres of the bronchial mucous membrane and blood-vessels. While all these agents relieve asthma, and, indeed. in some cases are indispensible, it is quite clear that in doing so they lower or depress the functions of the parts on which they act, and that they do not, therefore, come up to the ideal of an asthmatic remedy. The best among them are nitro-glycerine, one or two minims of a one per cent. solution every three or four hours, by the mouth, and 1-20 or 1-10 of a grain of morphine hypodermically once or twice a day.

What, then, is the remedy which may be given continuously for the alleviation of this disease, and without the undesirable effects of the above-named classes? Which drug will relieve asthma in stimulant doses? Such a drug, I believe, we possess in strychnine. Of course we must bear in mind that all stimulants are only supplementary agents which maintain the functions of the body without adding any direct material support to the same; but there is also good reason for believing that they cause the tissues to appropriate a larger amount of nutritive material than they would otherwise do; and in this way our stimulant drugs become tissue-builders. It has been shown that the power of strychnine in this respect is greater than that of any other stimulant. This drug has a special affinity for the nervous system, which action is especially accentuated on the pneumogastric nerves. In stimulant doses it gives a supporting influence to the respiratory movements, and, unlike morphine, lobelia, belladonna or nitro-glycerine, it does not depress or narcotize the nervous system. Asthma being a spasmodic disease, in what manner does strychnine bring relief? How does it act as an anti-spasmodic? The most probable theory of the spasmodic state is that there is at the beginning of the paroxysm a superabundant discharge of nerve force through the pneumogastric nerves, which throws the bronchial muscles into contraction. But whatever the intimate nature of this condition may be, it is evidence of nerve degradation or nerve weakness, and strychnine, by elevating the tone of these nerves, increases the controlling power of the same.

A stimulant dose of strychnine will depend upon the age of the patient and the length of time during which the drug has been given, although asthmatics, as a rule, will bear larger doses of strychnine than most other patients. Begin, as a rule, with 1-30 of a grain subcutaneously once a day, and gradually increase to 1-20 or 1-10 of a grain, or more, if necessary, to impress the system with its full stimulant effects. Do not waste your time with small doses. To these amounts of strychnine small doses of from 1-400 to 1-600 of a grain of atropine may be added. It is best to administer these drugs in the evening, because asthma is nocturnal in its attacks, and your patient should be protected at night so he can sleep. Additionally to its hypodermic use, this drug may be given in the following combination:

℞—Phenacetini.....gr. lxiv.
Quininæ sulph.....gr. xxxii.
Ammon. muriatis... ʒ iss.
Pulv. capsici.....gr. iv.
Strychninæ sulph...gr. 1½.
M. Ft. capsulas No. xxxii.
Sig. One capsule four times a day.

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Or in the following:

℞—Strychninæ sulph.....gr. 1/8
Syr. acid. hydriodici.....
Syr. hypophosph., aa...fl ʒ ij.
M. Sig. One teaspoonful four times daily.

In fact, light cases of asthma require no hypodermic injection, and do well enough when the above-named preparations are given. In severe cases it is of course advisable to add morphine or nitro-glycerine to the strychnine and atropine treatment, especially at the beginning. This treatment will break up he paroxysms, but even after they are broken many old asthmatics still remain in the most abject misery. They may be compelled to sit up day and night panting for breath, and still labor under the impression that they are suffering from asthma. This is a mistake; it is not asthma, but the natural state of exhaustion which follows asthma. The respiratory movements, as well as the whole nervous system, are almost paralyzed. It is the disorder and chaos following the flood. The dyspnœa is not paroxysmal as before, but is felt now on the slightest exertion. This stage of the disease is most important from a therapeutic standpoint. Nitro-glycerine, lobelia and other narcotics are of no use. Rest is most essential now. They must absolutely do nothing—lie down, if they can, or sit still. They should even be fed. I have known patients who were breathing comfortably bring on a most severe exhaustion—dyspnœa—by merely undertaking to write a letter. During the rest treatment give food of the most nourishing character, such as freshly expressed beef-juice, a cupful a day; beef powder, beef, mutton, milk, oysters, clams, etc. In this stage strychnine is also of the greatest value. Massaging is also to be used in desperate cases. Electricity is also of great service; so are rarefied air and calisthenic exercises obtained in the pneumatic cabinet treatment. To procure sleep at night, morphine may be added to the hypodermic injections of strychnine.

Success in treating asthma depends as much in the proper management of the individual as it does in the administration of drugs in the proper doses and at the proper time. Principles can only be carried out by paying attention to details; hence each patient must be under the complete control of his physician in regard to his food, exercise, medicines and everything else. This pertains particularly to old asthmatics who are severe and constant sufferers. If the instruction given this evening is closely followed, there are very few cases of this disease which will not yield, and as an illustration of what may be done in desperate instances, I will conclude by relating the condensed histories of the two following examples, the second of which I have still under occasional treatment:

Case 1. A., aged 46, a sufferer from asthma for thirty-five years—the attacks becoming more frequent and severe during the last three years. For four weeks before coming under observation he had been unable to lie down on account of his disease. The injection of strychnine, gr. 1-25, and morphine, gr. 1-15, gave him almost immediate temporary relief. The morphine was discontinued after the second day, and one minim of one per cent. solution of nitro-glycerine every four hours was substituted. The strychnine was gradually increased and the nitro-glycerine omitted in the course of a week. Additionally he was kept quiet, received nourishing food, and strychnine by the mouth. In three days from the beginning of treatment he was able to lie down, and in ten days more the asthma had disappeared.

Case 2. B., aged 50, an asthmatic for twenty-five years. Daily attacks for one

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year, during which time he had been unable to lie down, day or night. Came under observation six weeks ago, and received about the same treatment as the previous case. The relief was prompt after each injection, but this had to be continued nightly for five weeks to keep the stubborn disease in abeyance. In two weeks he was able to lie down, and is now practically well.

Selected Papers.

THE SIGNS OF ACUTE PERITONEAL DISEASES.

By Dr. Samuel Gee.

In the Bradshaw Lecture, delivered before the Royal College of Physicians of London, by Dr. Samuel Gee (*British Medical Journal*), the author says that the peritoneum has functions, no doubt, but they are so unimportant or so obscure, that however much they may be disordered, there are no symptoms peculiar to the consequent disease, and for this reason the ancients failed to recognize peritonitis as a disease of the peritoneum. When the abdomen was opened in a case of peritonitis it was the highly inflamed viscera that attracted the attention without any thought as to what part of these was first affected. and the terms gastritis, mesenteritis, enteritis, etc., were invented to designate this condition of the different organs. In the latter part of the eighteenth century Suavages invented the term peritonitis, but it was applied to inflammation of the parietal peritoneum only; so that Cullen, in his *First Lines*, disposes of the disease by saying when it exists alone it is hardly to be recognized, and does not require any special treatment. The first essay on peritonitis conceived in the modern spirit was from the pen of Laennec in 1803.

He gives the local signs of peritonitis as three—pain, meteorism and ileus. Broussais speaks of pain as the only pathognomonic sign, but he fears there is no pathognomonic sign at all. The earlier physicians called the pain of peritonitis colic; and it is highly probable that they were often right, and that much of the spontaneous and paroxysmal pain is due to colic—that is to say, to vermicular contractions of the intestines much more powerful than usual. Is the tendernoss of the abdomen to pressure due altogether to pressure upon the peritoneum? The skin is also tender sometimes to the gentlest touch. The scalp is sometimes so tender in cases of meningitis as to cause intense pain in being shaved. Simple colic may be accompanied by the greatest tenderness on pressure, and he commends these facts to those who find a difficulty in believing that leeches or blisters applied to the skin can possibly affect a deeply-seated part with which the skin has no obvious connection.

The pain is in great part intestinal, meteorism and ileus entirely so. The pain is in great part due to intestinal spasm, the last two to intestinal paralysis. The hollow viscera with muscular coats are the only viscera which are directly affected by the peritoneal inflammation, and this affection takes the form of spasm or paralysis. Patients with peritonitis are often unable to pass their water, whether from paralysis of the bladder or from inability to start the reflex act may be open to question; the latter is probably the more usual cause. But about the intestinal paralysis there can be no doubt. It manifests itself in its earlier and slighter degrees by meteorism or acute flatulent distension of the bowels. I do not speak of that peritoneal meteorism which is due to the escape of air into the peritoneal cavity in consequence of rupture of some part of the alimentary canal, but of that intestinal meteorism only which is second-

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ary to peritonitis. Intestinal paralysis is no longer a matter of inference. Abdominal section nowadays often gives surgeons the opportunity of seeing how intestines which, when first exposed, were in active movement, afterwards become exhausted, and lie limp and motionless. This intestinal paralysis is not continual or not universal, for in patients whose abdominal walls are thin, vermicular movements of the intestines, either spontaneous or produced by handling the belly, can be seen sometimes in spite of very great meteorism. But this is an exception to the rule. Usually no intestinal movements can be seen, and probably none occur, or else they are too weak to show themselves. So we may suppose that the flatulent distension is due partly to relaxation of the intestinal walls and partly to weak peristaltic movement insufficient to pass the wind onwards, a condition closely resembling constipation. This torpid meteorism, I just remark in passing. may be attended by great and constant pain—a fact which seems to show that the pain of peritonitis is due not altogether to colic or painful intestinal contractions, but partly to the inflamed peritoneum itself. Another proof that the intestines are not so utterly paralyzed as might at first seem likely, or that the large intestine at any rate escapes, is afforded by the fact that natural defæcation, or even diarrhœa, will accompany acute peritonitis.

Ileus marks a higher degree of intestinal paralysis with disorder of the peristaltic function and disability to propel its contents. The sign of ileus is vomiting becoming fæcal. The father of physic has well described the course of events, the matters vomited being first mucous, afterwards bilious, and lastly fæcal. Until the vomit become fæcal, or at least porraceous (meaning thereby an appearance like chopped grass or spinach), it is impossible to affirm the existence of ileus. The concurrence of constipation is no help, and indeed, on the other hand, fæcal vomiting may be attended by the evacuation of small loose stools, resembling in color and other respects the pale, uniform, pasty intestinal contents found in cases of mechanical obstruction. I need not stay to bring proof that stercoral vomit may be due to obstruction in the ileum; and thus the question, formerly so much debated, of possible reflux through the ileo-cæcal valve, loses its interest. Nor need I discuss the mechanism of fæcal vomiting, or say more than that there is no evidence of inverted peristaltic movement of the intestines. If enemata ever become emetic, as Sydenham says they do, it can only be by absorption into the circulating blood, just as vomit may smell of turpentine after the use of that drug in a clyster.

GENERAL SYMPTOMS.

Fever.—Let us now pass on to consider the remote or universal effects of peritonitis. And first of fever. No symptom is more uncertain than this; the temperature being sometimes high, and reaching 105° or more; usually but moderately raised; whilst in other cases there may be no fever at all, so far at least as can be judged by a thermometer in the mouth or axilla. This pyrexia is a remarkable symptom when present, as it sometimes is, from first to last in peritonitis the most intense and fatal. We are tempted to speculate upon the cause of so strange a phenomenon; whether an ordinary febrific poison be not produced by the inflammation, or whether an extraordinary febrifuge poison be produced; at present we cannot do more than note the fact. Apyrexia sometimes becomes algidity; an important sign of the lipothymial state to which I shall soon refer.

Putridity.—More certainly due to an infection of the blood are the putrid or septhæmic symptoms which sometimes happen. When we bear in mind that Bichat pointed out that the peritoneal cavity is a lymphatic sac, with a most extensive absorbing surface, and an extraordinary power of absorption, the wonder is that these symptoms do not occur oftener. I will illustrate this form of disease by the case of one of our students at St. Bartholomew's. He was running along the street and got a heavy fall, which was the only discoverable cause for the acute peritonitis that occurred within forty-eight hours. Delirium and diarrhœa were associated with the abdominal pain and vomiting of the first few days. On the sixth day he complained chiefly of pain in his joints; his feet and one shoulder were swollen

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and excessively tender. The skin over the feet, wrists and ankles was red in patches. His urine was highly albuminous, but no blood corpuscles or casts were found in the sediment. The diarrhœa continued; he lay in a state of typhomania—that is, of delirium with consciousness much impaired. He had a greater tendency to chills and occasional shivering than is usually met with in cases of peritonitis; the temperature varied between 102° and 105°, until a few hours before death, which occurred on the eighth day. At the post-mortem examination nothing was found but peritonitis and its results; its cause was not found.

Lypothymia.—I will next speak of that marked failure of the vital functions (that is to say, of the circulation, respiration and body heat) which very often accompanies peritonitis. It is a matter for surprise and regret that we have no term in common use to express this set of symptoms. No English word being precise enough, I suggest that we resuscitate the Greek word lipothymia to denote *defectio animæ*, this failure of the vital constitution, whether it be attended or not by lipopsychia, *defectio animi*, or failure of the animal constitution marked by coma, delirium, or both. Sudden lipothymia is syncope or swooning, syncope due to injury is shock. Lipothymia is manifested by a small, weak and sometimes irregular pulse, by weakness of the heart sounds, by shallow breathing, by lividity with pallor (deathly paleness), and by algidity or failure of the body heat, at least so far as the skin is concerned; the inner heat, as measured in the rectum, may or may not fail to a proportionate degree. In peritonitis—apart from perforation—lipothymia sometimes marks the whole course of the disease—and when to lividity, coldness of skin and a weak small pulse are added diarrhœa with watery stools and suppression of urine the resemblance to cholera is great indeed. But more frequently lipothymia occurs only towards the end of life, and then it may assume, so far as the body heat is concerned, the form of lipyria—another ancient word, which might be revived with advantage—that is to say, while the skin, especially of the limbs, is quite cold, the temperature of the inward parts, as measured by a thermometer in the rectum, is much above the normal; it may be 105°—a very bad prognostic sign in all acute diseases, and a plain proof of the extreme weakness of the circulation.

Lipothymia without Pain. — Another sign which sometimes attends this final lipothymia—this mortal agony or struggle with death—a sign which has attracted the notice of physicians from the earliest times—is the disappearance of pain and suffering whilst the patient remains perfectly conscious; yet all the symptoms of vital failure persist, and he only whose attention is fixed upon the local signs to the neglect of the prognostic condition of the whole patient can be surprised by what will seem to him to be a sudden and unexpected death. 'Twere curious to inquire into the causes of this cessation of pain, whether it be due to cessation of cramp, whether an anodyne poison be produced in the course of the disease, whether the lipothymia arrest the nutrition of the nerve endings, or whether the sensorium for pain be similarly affected, but I will say no more than to remind you, Sir, that an honorable predecessor of yours in that honorable chair—Sir Henry Halford—once read before the College an essay dealing with this very topic.

Lipothymia without Abdominal Signs.—Still more remarkable, although much less common, is the case of peritonitis attacking a healthy person, lipothymia supervening in the course of a few hours from the beginning, and any local signs of abdominal disease disappearing at the same time. The patient when first seen makes little or no complaint of the abdomen; it is not swollen, and can be pressed deeply without causing pain. But the skin is cold, the heart beats very frequently, no pulse can be felt at the wrist, the respirations are very frequent, the secretion of urine is suppressed. The mind is affected little or much. The patient dies on the first or second day of illness. At the post-mortem examination acute peritonitis is found, but not necessarily perforation of the peritoneum or disease of any other abdominal structure.

Facies.—The last sign of acute peritonitis which I shall notice is that afforded by the look and expression of the face. These signs and such as these, which constitute the prognostics so much trusted by the earlier physicians, can be

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learnt in no other way than by a long familiarity with disease. If I allude to the countenance which still goes by the name of "facies Hippocratica," it is only to remark that Laennec has endeavored to walk in the footsteps of his great predecessor, and to depict an expression of face often seen in peritonitis and other severe abdominal diseases. This peculiar look, which he calls *face grippee*, is due chiefly, if not wholly, to the features being drawn upwards, so that the forehead is more or less wrinkled, and the naso-labial furrows are drawn inwards and upwards towards the root of the nose and inner canthi of the eyes. I have compared Laennec's verbal picture with the living patient, and have found it to be true to Nature—but not universally true, not present in every case of acute peritonitis. Indeed, I think that the *face grippée* denotes abdominal pain, and that it usually disappears with the pain, although the disease continue. But we must admit that the local suffering and local signs of disease may be very small, and yet the onset of peritonitis be denoted by a profound change in the expression of the patient's features. Surgeons remark this change when an operation is followed by peritonitis; physicians, also, when a perforation occurs in the course of typhoid fever. But peritonitis may be latent not only to its local symptoms, but may be altogether latent, manifested neither by local nor universal symptoms, being intercurrent with such diseases as ascites, renal dropsy, pyæmia or typhoid fever, the peritoneal inflammation being revealed by the post-mortem examination only. Our surprise at this latency diminishes when we reflect that the signs of peritonitis have little or no relation to the peritoneum, but depend upon disorder of other viscera, adjacent or remote.

Does peritoneal perforation yield any peculiar physical sign? None, unless peritoneal tympanites occur; and this depends, of course, upon whether the perforated cavity contains air. Physical examination does not yield a certainty as to the presence of air in the peritoneal sac; absence of the liver dulness is a useful, but not altogether trustworthy sign, for greatly distended intestines sometimes insert themselves between the liver and the parietes, and on the contrary in cases of adhesion of the convex surface of the liver to the parietal wall would give rise to dulness on percussion even in peritoneal tympanites. The signs afforded by auscultation are less important, because they are common to a great collection of air within the abdomen, whether within the stomach or intestine, or free in the peritoneal sac. A valuable sign is afforded by subcutaneous emphysema, which is, of course, limited to peritoneal tympanites. While the presence of these physical signs is a great help, their absence proves nothing. Perforation of a part of the alimentary canal (for instance, the appendix vermiformis) may occur and be followed by acutest peritonitis, and yet may be unaccompanied by peritoneal tympanites; nothing escapes from the rupture but offensive and poisonous pus. Perforation may occur with pain as the chief symptom, or ileus without pain or shock, or shock without the other two symptoms; or it may be latent; that is to say, unattended by any symptoms adequate to the diagnosis. Not that they are altogether absent, but they are rendered obscure by occurring in the course of some other disease marked by no less serious disorders. But perforation, latent so far as symptoms are concerned, will sometimes yield one or more of the physical signs of peritoneal tympanites. For instance, in the latter stage of typhoid fever, a rapid and great distension of the belly, such as to stretch the skin and make it shine and attended by disappearance of the liver dulness on percussion, is a tolerably trustworthy sign of intestinal perforation, and is sometimes the only token.

To conclude by referring once more to puncture of the peritoneum as a means for ascertaining the presence of inflammatory effusion. A small incision would seem to be justified by conditions such as these: First, the patient is suffering from acute peritonitis, and the indications of poisonous infection of the blood are becoming more and more marked; or next, there are reasons for believing that perforation of the peritoneum has occurred. In either case, unless we can bring relief, the patient must die. A small incision will not make him worse; nay, to drain the peritoneal cavity affords a chance of recovery; the only objection lies in the natural dislike

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to an operation, however small. I wish I could believe that chloroform sleep did no harm, but I fear that this drug has a depressing effect upon persons suffering from acute peritonitis. However, suppose a small incision made, and we find that the peritoneum contains pus or air, beyond simple drainage two further courses lie open to us; we may follow John Hunter's suggestion, and wash the belly out with warm water, a proceeding more serious than simple drainage, or we may enlarge the incision and search for the cause of the peritonitis, a proceeding highly dangerous, for you will, I think, agree with me when I say that operations of this kind have seldom any other effect than to hasten the patient's end. A simple puncture, if it do not save the patient's life, will at least bring the satisfaction of knowing that the nature of the disease has not been misunderstood.

—*British Medical Journal.*

ELASTIC CONSTRICTION AS A HÆMOSTATIC MEASURE.

By Nicholas Senn, M.D., Ph.D.

Dangers Attending Elastic Compression of a Limb.—Compression of a limb by an elastic bandage, as a preliminary step to elastic constriction, secures for the tissues at the seat of injury or the field of operation perfect ischæmia, but is attended by two sources of danger:

1. When resorted to in the treatment of a recent injury or an infective inflammation, it might force pathogenic microbes from the wound or the seat of inflammation into the general circulation, thus adding a general to a local infection, with all the additional risks incident to such a condition.

2. In operations for malignant disease, carcinoma or sarcoma, it might force tumor-cells into the surrounding tissues, or through the lymphatic or blood vessels into the general circulation, causing thus regional or general dissemination of the disease. These two sources of danger are not imaginary but real, and every surgeon with considerable experience can recall instances where elastic compression could be made answerable for the diffusion of an inflammatory process or the dissemination of a malignant tumor. Fortunately, Lister's experiments on the horse have demonstrated that, for all practical purposes, bloodless operations can be made without the use of the elastic bandage by simply placing the limb in a vertical position for a few minutes prior to the application of the constrictor.

Diminution of Blood-Supply to the Limb by Gravitation.—The influence of the force of gravitation on the supply of a limb becomes apparent by placing the arm in different positions. If one of the upper extremities is allowed to hang by the side of the body, and the muscles are fully relaxed, the veins become turgid, the capillaries distended, and the volume and force of the radial pulse markedly increased, and a sense of fulness and weight is experienced. If the arm is now elevated and held in the vertical position, within a few minutes the cyanosed appearance of the skin disappears and gives way to pallor, the overdistended veins collapse and are emptied of their contents, the radial pulse loses much of its volume and force, and the sense of weight and fulness is promptly relieved. If the limb is maintained in this position for five minutes, it is emptied of blood sufficiently to render operations, for all practical purposes, bloodless at any point below the elastic constriction. If an anæsthetic is used, elevation of the limb and the application of the elastic constrictor should not be done before the patient is thoroughly under the influence of the anæsthetic, as muscular relaxation is a material aid in securing a comparatively bloodless condition of the limb.

Form and Application of Constrictor.—Many surgeons have been in the habit of using a small solid rubber cord or a rubber tube of small size as an elastic tourniquet. Both of these forms of elastic constrictor are objectionable, as in either instance linear constriction is made, which, particularly if the force employed be excessive, as is so often the case, is so liable to cause temporary or

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permanent damage of some of the important tissues interposed between the skin and the underlying unyielding bone. The compression should include a ring at least two inches wide, in order to distribute the pressure over a larger area, in which event important structures are more likely to escape injury.

The best instrument for elastic constriction is a strong band of rubber at least an inch in width, of which at least two turns are applied side by side. In the absence of such a constrictor a soft rubber tube half an inch or more in diameter, an ordinary rubber bandage, or an elastic suspender should be used. As soon as the limb has been drained of its blood to the requisite extent by position, the constrictor is applied with sufficient firmness to interrupt at once both the arterial and the venous circulation. Simple as this advice may sound, it is nevertheless a fact that frequent mistakes are made in applying the constrictor properly. It is of the utmost importance that the pressure should first be made on the side of the limb occupied by the principal blood-vessels. If pressure is made first on the opposite side of the limb, the superficial veins are constricted first, and before the arterial circulation is interrupted, the limb presents a cyanotic appearance caused by an intense passive venous stasis. If, on the other hand, the elastic pressure is applied in such a manner as to arrest the principal arterial blood-supply first, venous return in the superficial veins is not interfered with until the circular constriction is completed, and the limb below the constriction is then in a comparatively bloodless condition, and remains so after the application of the constrictor. Some tact and experience are necessary in regulating the force required to interrupt quickly and completely the arterial and venous circulation. Less force is required, of course, when the main blood-vessels are near the surface and close to a bone than when a thick layer of muscles is interposed between skin and blood-vessels and the underlying bone. Pressure beyond the required degree, especially if continued for an hour or more, is liable to result in injury of muscles and nerves, and should be carefully avoided. Instead of using the chain or tying the constrictor in a knot, it is better after encircling the limb at least twice to cross the constrictor and fasten it between the blades of a heavy hæmostatic forceps. A well-recognized disadvantage of elastic constriction as a hæmostatic measure is *increased parenchymatous hæmorrhage.*

The profuse capillary oozing which so often follows the removal of the elastic constrictor, is undoubtedly, at least in part, due to a temporary vaso-motor paresis caused by the constriction. This result is obviated most successfully by keeping the limb in an elevated position at the time the constrictor is removed, and by maintaining this position for at least six hours. The intravascular tension is reduced to a minimum by elevation of the limb, and this condition is most conducive to the formation of a minute thrombus in each of the small vessels—capillaries, arteries and veins—divided during the operation. Another exceedingly useful resource in diminishing unnecessary loss of blood, after all visible vessels have been ligated and the constrictor has been removed, consists in making firm pressure against the wounded surface. This is most effectually done by using a moist compress of gauze large enough to cover the whole surface, which is firmly held against the wound with one or both hands. After an amputation, for instance, all the principal vessels should be sought for and tied before the constrictor is removed, and the limb held in a vertical position. A compress of moist gauze is then placed against the wound surface, the flaps brought over it, and firm compression made over the end of the stump with both hands for at least five minutes. If the capillary oozing does not yield to this treatment, the wound should be irrigated with sterilized water at a temperature of 110° F., which makes a delicate white film on the surface, and has a very prompt effect in definitely arresting the bleeding. In obstinate cases the addition to these expedients of an application of peroxide of hydrogen serves an excellent hæmostatic purpose, and does not interfere with primary union of the wound.

Other complications arising directly from elastic constriction are:

Temporary Loss of Muscular Power and Nerve Paralysis.—These consequences undoubtedly are often the direct outcome of a faulty use of the

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constrictor. The experiments made by me show conclusively that firm constriction, continued for several hours, almost invariably results in loss of function of the limb, which continues for several days or weeks. In these instances the disability was undoubtedly due to injury of the constricted muscles. If in the use of the constrictor more force is used than is necessary to interrupt the circulation, and particularly if linear pressure is made, injury of the muscles exposed to this undue pressure is very likely to be produced. The same can be said of injury to the nerves from the same cause. Two cases of nerve paralysis resulting from elastic constriction have occurred in my own practice.

For the purpose of preventing injurious pressure on nerves from elastic constriction, it is necessary to tie only with sufficient firmness to interrupt the arterial and venous circulation, and the pressure should not be linear, but distributed over a wide area, a ring at least one inch or two in width. The last requirement is best attained by using a wide band, or if an elastic tube or cord is used, the limb should be encircled several times, each turn drawn with uniform force and arranged in such a manner as to compress with equal firmness a wide circle, thus exerting the same effect on the tissues underneath as pressure made by a wide band. If for any reason the constriction cannot be made at a point where the principal nerves are well protected by a thick layer of muscular tissue, a thick compress of gauze should be placed between the constrictor and the limb, in order to protect the nerves against injurious pressure.

Necrobiosis and Gangrene Following Elastic Constriction. — Experimental research has shown that an ischæmic condition and elastic constriction, for two hours or more, are liable to produce an unfavorable influence on the karyokinetic processes in the tissues deprived of blood for this length of time. This is sufficient proof that prolonged constriction retards the healing process. Necrobiosis, slow healing and necrosis of margins of the wound are some of the remote consequences which follow prolonged constriction of a limb.

In the use of Esmarch's constrictor in arresting hemorrhage that threatens life, it is practically not necessary to distinguish between venous and arterial hæmorrhage. It was the consensus of opinion of the members of the military section of the last International Medical Congress in Berlin, that it is no longer wise nor practical to differentiate between arterial and venous hæmorrhage in rendering the first aid to the wounded on the battle-field, or in a case of accidental hæmorrhage; that the one point that must be taught the soldier, the brakeman and the conductor is, that if hæmorrhage is so profuse as to threaten life before medical aid can be summoned, it should be at once arrested by elastic constriction—by a suspender, if nothing else is at hand—applied invariably on the proximal side of the seat of the injury. The constriction must be made with sufficient firmness to arrest completely both the arterial and venous circulation, as has been repeatedly insisted upon above. By applying the constrictor only with sufficient firmness to diminish the arterial circulation the venous hæmorrhage is increased. It is by overloading the tissues with venous blood by imperfect constriction that gangrene is invited and venous hæmorrhage increased.—*International Med. Magazine.*

OPERATION FOR THE RADICAL CURE OF INDIRECT OR OBLIQUE INGUINAL HERNIA.

By F. O. Summers, M.A., M.D.

Having operated with satisfactory results upon a sufficient number of cases for the radical cure of oblique inguinal hernia, to report positively upon the subject, I desire to lay before the profession, through your columns, my method of operating, that it may be considered by those who are interested in this line of surgical work. I shall not take up time or space in the review of hernia and the methods which have been adopted for its cure—whose name is

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legion—but simply state my own method, which has proved absolutely successful in so many cases that I feel justified in offering it as a fixed method of operation for radical cure.

I generally operate without general anæsthesia where the patient is willing to trust to my assurance that there will be but little or no pain connected with the operation. The local injection over the parts of a solution of cocaine hydrochlorate, five (5) grains to the half ounce of distilled water, will generally prove sufficient—using about two hypodermic syringefuls—one at each end of the inguinal canal—external landmarks.

I then invaginate the scrotum—after, of course, reducing the hernia—with the forefinger of my left hand, carrying it as far as possible up the canal.

With a canula needle I pass a silver suture (No. 26) from right to left, including the scrotum on the end of the finger. Clipping that, I pass another from above downward under the former, and then a third across in the axis of the canal. The ends are all then drawn together respectively and firmly twisted, a compress and bandage applied and the patient kept *absolutely* quiet for four days, when the sutures may generally be removed, although it is safer to let them remain for a week, after which time a bandage or light truss is worn until the neoplasm is complete. Generally the integument of the scrotum will come back down through the canal gradually, leaving the dartos and tunics plugging the cavity, closely attached to the walls of the canal remaining as a permanent and complete obstruction to the passage of the intestine. This is very simple, but in my hands it has proved a brilliant success.—*N. O. Med. and Surg. Journal.*

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Editorial.

THE JOURNAL UNDER ITS NEW MANAGEMENT.

With this first issue of the New Year the JOURNAL is presented to its readers in new form, with a complete new dress and under a new management. In entering the field as medical journalists, and soliciting the support of the profession, we do so with a full appre ciation of our responsibility to that profession, and of the persistent endeavor that will be necessary to bring any degree of success. Especially do we realize how great a task is ours in maintaining for the JOURNAL, whose conduct we have assumed, the dignity and the high degree of excellence which has characterized it under its former able management. With a deep sense of the obligations we have taken upon ourselves, we would ask our friends to take a glimpse into the future with us that they may know what the object is toward which our efforts will be directed, and how essential is their co-operation to the successful carrying out of our purpose.

Many of our readers will remember the discouraging conditions under which the JOURNAL was established—in the very face of the adverse report of a committee appointed to consider the advisability of establishing a journal of the Society. But its intrepid founder, whose death the profession has but recently been called upon to mourn, felt the great need of such a thing, and with an associate boldly undertook the work. However, in a year or two he was left to bear the burden alone, and it is to his peculiar ability and persevering labor alone that the JOURNAL owes its present high standing in the great army of medical journals. In the December number the retiring editor referred briefly to the many trials that marked the early years of the JOURNAL, and mentioned the fact of his having been associated with Dr. Wood on the editorial staff since the year 1886. It is left for us to inform our readers that upon his worthy shoul-

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ders fell nearly the whole burden of conducting the JOURNAL during a great portion of Dr. Wood's illness, and the excellent manner in which his labor of love was performed, even in the midst of a large and important practice, speaks for the wisdom of the choice that made Dr. Geo. Gillett Thomas the junior editor of the JOURNAL.

In changing the form of the JOURNAL we have done what was often in the mind of the former owners, and what we consider to be a desirable thing. The double column page is the form adopted by the leading periodicals of the day, and presents the matter in a shape more easily read, it requiring less effort to pass from line to line. While the number of pages is smaller, the amount of reading matter in each issue is increased, the excess being equal to about eight of the old-style pages. We congratulate ourselves and our readers that we are able to present to them a corps of collaborators whose eminence in their profession, and whose rich experience and enviable reputation as practitioners and writers, will ensure the JOURNAL a high degree of excellence and usefulness. The gentlemen whose names appear upon this staff need no introduction to our readers. They represent the most advanced thought and the highest skill in medicine and surgery in this section. Those of our own State are from among our most distinguished physicians, all holding at this time offices of honor and trust, and they are supported on either flank by the brightest lights of Virginia and South Carolina.

It is our aim and hope to make this Journal, while bearing the long-respected name "NORTH CAROLINA MEDICAL JOURNAL," the Journal of the Carolinas, and the medium through which the work and the talent of the profession of these two States may be made known to the world, and exert their influence in the rapid progress which characterizes the science of medicine at this time. To this end we solicit the support of the physicians of North and South Carolina especially, and of the Southern States generally. We ask both for their subscriptions and their contributions. To the young men whose ideas have not become settled down into ruts and grooves by long practice and prejudice, and who have recently returned from the great centers with their minds pregnant with modern ideas, we look for many bright suggestions in therapeutics and surgical procedures; and to the older men who have learned by years of experience the value of many "old time remedies" (so-called) which are apt to be overlooked in the great desire of the times to run after new things, we look for much wise counsel and timely advice.

It has been a peculiar characteristic of our Southern doctors that they will not write, and we take this opportunity, as we will make many others, to urge upon them the importance of making their experience known to others. This is the season which custom has made the time for good resolves, and it is a good time for you physicians to resolve to turn over a new leaf, and do more literary work in your profession. Do not wait to write an elaborate essay upon some vexed question in theory, or to report some rare case which may never come into the experience of the majority of those who would read the report; but keep notes of your daily practice and report the results of special lines of treatment in the diseases which make up the daily experience of the doctor. The busy practitioner has little time for reading, and he wants to get the most good he can in that time; and when a long-drawn-out paper finds many readers it is the exception, and depends in great measure on the author's pleasant

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style of writing. Do not excuse yourselves by saying that you are too busy to write; it is the busy physician who has the rich experience, and it is his duty to make the result of that experience known. He is rather to be excused for not writing who has the most time. The more time, the less experience; the less time, the more experience.

We propose to give our readers many valuable papers in our Original Department, and while we hope to draw largely upon our home talent for this matter, we will present papers and lectures from the eminent practitioners and teachers of the great cities. We will present abstracts from Society Reports, and in this connection we solicit condensed reports from county societies in the Carolinas. Many good papers are read at these meetings which never, probably, go beyond the walls of the building in which the meetings are held. The journals of this and other countries will be carefully scrutinized for instructive and interesting matter and abstracts presented of the more important papers; recent literature from the more important medical publishing houses will be noticed and reviewed impartially; and space will be devoted each month to therapeutic suggestions, where will be found many favorite formulas of successful practitioners.

A new feature which will be of interest to many of our readers will be a space where paid-up subscribers desiring to change their locality, and purchase or dispose of practice or property, may make their wants known free of cost.

As it has done in the past, so in the future will the JOURNAL give its whole influence to promoting the welfare of the Society of which it has the honor of being the official organ, to elevating the standard of medical education, and to preserving the honor and dignity and advancing the interests of the profession. We hope to merit and have the support of every physician of the Carolinas, and especially of the members of the State Societies, and to see the JOURNAL go on increasing in popularity and usefulness.

In conclusion. we beg to remind our friends, who have gotten in arrears with their subscriptions, of the great importance of prompt payments for maintaining the standard of usefulness which will do honor to the Society and the State Profession, and ask those, who have not done so already, to remit as soon as possible the amount of their accounts as sent to them a few weeks since.

Asking the pardon of our readers for having consumed so much of their time, and with feelings of great encouragement due to the many kind expressions that have come to us, we extend to them all friendly greeting, with our heartiest good wishes for their happiness and prosperity during the New Year.

PRESENT STATUS OF WOUND TREATMENT.

With the advent of the New Year it well becomes the profession to consider briefly the present most approved methods of treating wounds.

With the passing of the years and the corresponding advancements in surgical procedures, the rash methods and wild speculations of the enthusiasts for rigid and thorough antiseptic measures have been greatly modified, and a salutary reaction has set in as regards wound treatment.

Since 1885 the pendulum of antisepsis has swung far out, but it is now vibrating towards a more agreeable and rational standard. Once it was supposed that it alone could meet all the requirements of surgical cases so far as preventing the entrance of pathogenic microbes into wounds, but now it is

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admitted by all reputable surgeons that asepsis, also, must be the prominent, if not the essential, feature in the performance of ordinary surgical operations.

In reviewing the surgical history of recent years, it is evident that antisepsis alone has not yielded the once promised results of brilliant success, while asepsis, on the other hand, has gained steadily in popular favor, and to-day, more than ever before, is claiming the recognition and endorsement of the profession.

Accordingly, the necessity for perfect and absolute cleanliness in all surgical cases is now deemed imperative, while the importance of chemical antisepsis is considered of far less value than in former years. The tendency now is to dispense with the elaborate antiseptic system of Lister, and, instead, simplify more and more the technique of surgical cases by the employment of thorough cleanliness and the utilization of heat as a germicide; and with these simpler methods, that are within the grasp of every practitioner of medicine, have come better and more satisfactory results.

No one who has had extended surgical experience can deny the possibility of wound infection from the air, and yet, in this sparsely settled country of ours, this is a factor little to be considered, except, perhaps, in operations upon joints, brain tissue, etc., and in these cases all precautionary measures should be undertaken.

Without elaboration, the following are the most noticeable points to be considered in the modern treatment of wounds, though, of course, the technique varies somewhat in the hands of different surgeons: The surface upon which the operation is to be performed should be thoroughly and diligently cleansed by repeated washings and scrubbings in hot soapsuds, frequently changed. The hands of the operator and his assistants should be subjected to the same conditions for at least five minutes, care being exercised to have the nails thoroughly cleansed and brushed. The instruments can best be sterilized by boiling them for twenty minutes in a pint of water, to which a heaping teaspoonful of bicarbonate of soda has been added, and they can be taken directly from this solution for operation.

Germicides.—The use of powerful germicides, such, for instance, as the strong bichloride solutions, 1 to 2,000, is becoming less popular, and they are employed now principally for cleaning sponges, tampons, etc.

The tendency is to use, after the first incision, either weak bichloride solutions, weak salicylate of sodium solutions, or simply boiled water, for, while it is admitted that the strong bichloride solutions may destroy the germs which gain access, it is also known that such solutions provoke irritation of the wounded surfaces and lessen the resistance of living cells, thereby delaying the processes of healing. Profuse irrigation of wounds is discountenanced also, for it encourages a serous exudation that interferes with prompt healing.

Ligatures.—Since ligatures are foreign bodies in wounds, the tendency is to dispense with them as much as possible. But if they are used, catgut, properly prepared, is preferred generally as the most suitable material.

Instead of ligatures, torsion of the vessels is relied upon. The pressure of the hæmostats is now much utilized for this purpose, but care must be taken in their use. The vessel itself should be seized alone if possible, for if the surrounding tissues are involved they are crushed and devitalized, and thus become foreign bodies in the wounds. Many major amputations have been performed successfully without ligating a single vessel.

Drainage.—The general tendency of the day is to dispense with drainage

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whenever it is possible, for the drainage-tube being a foreign body, is open to many objections. This can be done in all clean-cut wounds especially, and even in some of the larger operations where there has been no previous infection with the ordinary pus microbes. In certain cases, however, drainage is absolutely necessary, and must be maintained.

Closure of the Wound.—Much attention is now devoted to this important procedure. The operation completed, some surgeons, just before the application of the sutures, have the wound flushed with a weak antiseptic solution, such as a 0.6 p. c. solution of chloride of sodium, while others prefer the use of sterile lotions, as boiled water or boiled normal salt solutions. Still others apply to the wounded surfaces a solution of zinc chloride, twenty grains to the ounce, thereby removing all shreds and coagula. This done, the whole wound is lightly packed with sterilized gauze, consisting of one long, narrow strip. The wound is then sutured over this gauze, great care being exercised to perfectly coaptate the surface, with the exception of one corner, through which an end of the gauze-packing is protruding. The gauze is then withdrawn through this aperture, while an assistant makes pressure with sterilized sponges over the wound cavity, and the wound is finally closed by knotting the last sutures which were placed before the gauze was withdrawn.

Dressings.—Most surgeons prefer to place over the line of incision a smooth surface, such as gutta-percha tissue or Lister's protective. When these are not at hand, a suitable and serviceable antiseptic paper can be prepared by making a solution of two and one-half drachms of bichloride of mercury to a pint of distilled water that has been boiled and allowed to cool, to which also six drachms of glycerine has been added, and immersing in it sheets of unsized paper, which are then allowed to dry. Over this is placed absorbent gauze or sponges covered with sterilized gauze, the quantity varying according to the amount of wound discharge expected; then comes a thick layer of absorbent or bichloride cotton, and, finally, a snug-fitting bandage. Such a dressing is often undisturbed for from four to twenty days, but usually the sutures are removed on the sixth or seventh day, and the wound is found entirely healed.

The above facts here collated and briefly considered are recited not so much to show the modification of the views once held upon the treatment of wounds, as to impress the practitioner, and especially the country practitioner, that he has at his command all the required materials for conducting the most approved aseptic operations, and that his removal from the great centres of medical learning and surgical paraphernalia is no excuse for his not always securing antiseptic results, even when the surroundings are most unfavorable and discouraging. The object of this article will not be gained if this point is not emphasized.

MEDDLESOME MIDWIFERY.

The proper management of obstetrical cases requires great skill. Notwithstanding this, these cases, involving, as they do, the health and life of at least two persons, are more often entrusted to the treatment and care of novices than any other class of cases.

The proper conduct of a simple obstetrical case, from its commencement through the puerperium, is almost as much a *quæstio vexata* to-day among the members of the profession as ever, but if there has been one lesson learned from the numerous experiments that have been undertaken, and from the many theories that have been promulgated and so enthusiastically endorsed,

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that lesson is that *too meddlesome midwifery is bad practice.* It is true that many obstetricians, either through a lack of knowledge or from carelessness and indifference, do too little for the safe delivery and after-comfort of their patients; and it is equally true that too many, in their ardor for antiseptic results, are too meddlesome in their conduct of confinement cases. Recently, the writer, having occasion to examine into this subject, found that one author, whose reputation is unquestioned in the obstetric art, advocated an antiseptic irrigation after every vaginal examination, and that later, in detailing a complicated case, he incidentally mentioned the use of twelve vaginal douches!

It is a fact that antiseptic midwifery demands absolute cleanliness, but from a comparison of the data as published by nearly forty writers, we find that the consensus of opinion is largely in favor of dispensing with the antiseptic vaginal douche altogether during puerperium, and never during labor, except as recommended by a few authorities, before the first examination, and perhaps once during the continuance of the labor, if it be a prolonged one, or if infection has been known to exist. Every infection during or before the birth comes from the air, the hands, or the instruments, consequently, as cleanliness is the first law of prevention, due regard must be had to these important points. The physician and all the attendants must be rendered as scrupulously aseptic by the lavish use of soap and water as the patient herself, and the physician should refrain from vaginal examinations unless absolutely required.

The air in the lying-in chamber should be pure and fresh, with plenty of sunlight; for while a dark room, with closed blinds and drawn portieres may be æsthetic, it cannot be considered conducive to convalescence. The clothing of patient and accoucheur, alike, should be kept free from soil, and all articles that come in contact with the patient should be thoroughly disinfected.

If all these injunctions be rigidly enforced, much has been done to lay the foundation for a physiological labor without subjecting the patient to the risk of poisoning from repeated vaginal and intra-uterine douches of toxic drugs.

TIME AND PLACE OF MEETING OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA.

At the last meeting of the Society Winston-Salem was selected as the place of meeting for 1893, and the time was left to be decided by the Committee of Arrangements. Since that time, however, Winston has suffered from a disastrous conflagration which destroyed the beautiful and spacious Zinzendorf hotel. As it is entirely out of the question to expect the hotel to be replaced in time for the Society meeting, and the other hotels being altogether inadequate to accommodate so large a body, the entertainment of the Society would of necessity devolve upon the individual courtesy of the citizens, but, while this certainly adds greatly to the enjoyment of the members, it has been found to interfere seriously with the work of the Society, in that members are thereby detained from the sessions. The profession of Winston-Salem have, therefore, as will be seen from the following communication received by the Secretary of the Society, abandoned the idea of having the Society meet in their city, but announce that the meeting will be held in Raleigh, beginning Tuesday, May 9th, 1893:

R. D. JEWETT, M.D., *Sec'y Medical Society of North Carolina:*

DEAR SIR:—The destruction by fire of our principal hotel has rendered the satisfactory entertainment of the mem-

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bers of the Medical Society of North Carolina, at its next meeting in this place, an impossibility. The Raleigh Academy of Medicine, appreciating our misfortune, has most generously offered us the privilege of holding the next annual meeting in Raleigh, and we have reluctantly accepted their courteous invitation. The next meeting of the Medical Society of North Carolina, therefore, will be held in Raleigh, N. C., beginning May 9th, 1893.

Yours truly,

HENRY T. BAHNSON, M.D.,
for the Physicians of Winston-Salem.

While many will feel great disappointment in that they will lose this opportunity of a visit to Winston-Salem, we can, in all sincerity, congratulate the Society in having fallen into such good hands as the profession of Raleigh have always proved themselves on such occasions.

THE SOCIETY PRIZES.

One word to the members of the State Society. For several years there has been a standing prize of One Hundred Dollars offered for the best essay on scientific medicine—to be original matter. The highest standard of excellence will be required, and the essay must give evidence of original research. The prize is known as the "Pittman Prize," having been established by Dr. N. G. Pittman, of Tarboro, in 1886, and is offered to members of the Medical Society of North Carolina only.

There is another prize of Fifty Dollars, known as the "Duffy Prize," likewise open to members of the Society. Essays in competition for this prize have heretofore been restricted to *Hæmorrhagic Malarial Fever and Its Treatment*, but Dr. Francis Duffy, of Newbern, has advised the Secretary of the Society that he has decided to widen the field for competitors by changing the restriction to "research into the Materia Medica indigenous to North Carolina."

We regret to have to say that only once since the "Pittman Prize" has been established has there been presented an essay in competition which was considered by the Committee as worthy of the prize. And while the "Duffy Prize" is not intended as a standing one, it seems in danger of becoming so because not won. At the last meeting of the Society two papers of considerable merit were presented, but were not upon the subject for which the prize was offered.

We call the attention of the members of the Society to these prizes thus early, with the hope that they will bestir themselves, and prepare essays in competition that will bring honor to the Society.

We well know, as do all, that it is not due to lack of talent in the Society that these prizes go over from year to year unwon, but it is, and can be, only indifference—we cannot call it modesty. Surely in a membership of nearly five hundred there will be found a few who have pride in the repuation of the Society, and will not permit the committees on these prizes to bring in the same stereotyped report, "No essay was presented of sufficient merit to be considered worthy of the prize," when the Society meets in Raleigh next May.

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Reviews and Book Notices.

A Manual of Medical Jurisprudence. By Alfred Swain Taylor, M.D., F.R.S., revised and edited by Thomas Stevenson, M.D., London. Eleventh American edited with citations and additions from the twelfth English edition, by Clark Bell, Esq., President of the American International Medico-Legal Congress of 1893. 787 pages, 56 illustrations. Price, cloth, $4.50; sheep, $5.50. Lee Brothers & Co., Phila., 1892.

This edition of this popular work is an entire revision of all prior American and London editions, and includes the admirable work with which Dr. Stevenson has enriched the twelfth English edition. Much new matter has been added, and in making additions upon legal questions and the present state of the law bearing on medico-legal matters, there have been cited nearly 700 cases and authorities. This, while not of great moment to the medical man, is an evidence of the thoroughness of the work which is intended for the legal as well as the medical profession. This work has long held the lead as authority in forensic medicine, and will probably continue to do so as long as such ably edited revisions are published. It should be upon the shelves of every medical man who may be liable to be implicated in a trial at court on medical matters, and which one is not?

Tuberculosis of Bones and Joints. By N. Senn, M.D., PhD., Professor of Practice of Surgery in Rush Medical College; Professor of Surgery in the Chicago Polyclinic, etc., etc. Illustrated with 107 Engravings (seven of them colored). In one handsome Royal Octavo volume. 520 pages. Extra cloth, $4.00 net; sheep, $5.00 net. Philadelphia: The F. A. Davis Co., Publishers, 1231 Filbert St.

Dr. Senn's careful research, clear and concise style of expression, originality of thought and extended experience, have rapidly gained for him a place as an authority in his branch. In his present work he has fully sustained his reputation as student and teacher, and has given us, without doubt, the most thorough and valuable treatise on the subject of tubercular disease of the bones and joints yet offered to the profession. He begins with a brief and interesting history of "white swelling and of the different steps and discoveries which led to the recognition of its tubercular nature. Chapters III and IV treats of the bacillus tuberculosis and the histology of tubercle, with a description of the best methods of staining, illustrated by colored plates of microscopical sections.

After describing the processes resulting in caseation and abscess, he goes on to the Topography of Bone and Joint Tuberculosis. Chapters IX to XII are devoted to tuberculosis of bone, Chapters IV to XXIV to tuberculosis of joints, in each the etiology, symptoms and diagnosis, prognosis and treatment being considered.

Chapter XXII is devoted to a description of tuberculin and a review of its history as a means of diagnosis and treatment. The greater part of this chapter is reprinted from the author's paper, which appeared some months since, entitled "Away with Koch's Lymph," and he explains that "this chapter has been written for the special purpose of placing myself on record as one who protests against further experimentation with this mysterious and dangerous fluid." The next two chapters describe the conditions for, and the method of. using intra-articular and parenchymatous injections of iodoform as a means of treatment, and gives the author's experience in the use of the treatment. He concludes that the method is indicated in all subcutaneous tubercular lesions of bones and joints accessible to this treat-

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ment; of all substances iodoform has yielded the best results; a 10 per cent. emulsion in glycerin or olive oil is the best form in which to administer it; an ethereal solution should never be employed; abscesses and joints containing synovial fluid should be washed out with a 3 to 5 per cent. solution of boric acid before the injection; injections should be continued at intervals of one or two weeks if symptoms of improvement show themselves, which will be not later than after the second or third injection; this method has yielded the best result in disease of the vertebræ and the knee and wrist-joint; it constitutes a valuable preparatory treatment where operation is necessary and adds to the certainty of a favorable result. Balsam of Peru ranks next to iodoform and should be tried if the latter has failed.

Chapters XXV to XXX describe the different operations of arthrectomy, resection and amputatton, with their remote result, and the last seven chapters treat of the disease as it affects the bones of the trunk and the special large joints.

In the treatment of coxitis the author dismisses the treatment by extension and immobilization in two short paragraphs. He claims the weight and pulley as the most efficient extension, and it should be resorted to in all cases in which pain is a prominent symptom and where the muscles around the hip-joint have become contracted. He says "extension by the different kinds of walking splints cannot be relied upon in cases in which this method of treatment is indicated." We are disappointed in that the author has not dwelt more at length on this part of his subject.

An American Text-Book of the Medical and Surgical Diseases of Children

Is announced by Mr. W. B. Saunders as in preparation, to be sold only by subscription. It is under the combined editorship of sixty-two distinguished physicians from all sections of the North and West. It will be similar in style to the text-book on surgery recently issued by the same house and which has had a phenomenal success, having been adopted as a text-book by forty-nine leading medical colleges and universities, with a sale of nearly five thousand to individual physicians.

International Clinics. A Quarterly of Clinical Lectures by Professors and Lecturers in the Leading Medical Colleges of the United States, Great Britain and Canada. Edited by John M. Keating, M.D., and J. P. Crozier Griffith, M.D., Philadelphia, and J. Mitchell Bruce, M.D., F.R.C.P., and David W. Finley, M.D., F.R.C.P., London. Cloth. Royal Octavo, pages 375.

The contents of each of these volumes are divided into the general heads of Medicine, Surgery, Gynæcology and Obstetrics, Neurology, Dermatology, Laryngology, Ophthalmology and Otology.

Vol. III contains forty-two lectures and Vol. IV forty-three, the latter also containing a memoir of Dr. Theodore Parks. Each volume is thoroughly indexed, and Vol. IV contains a general index. It would take several pages to reproduce merely the titles of the papers presented in these two volumes, with the names of the authors. We must satisfy ourselves with simply citing a few that our readers may have an idea of the wealth of interesting and valuable matter is here offered to them.

Under the section devoted to *Medicine* we find Various Forms of Purpura, by Thomas Oliver, A.M., M.D.; The Reduction of Temperature in Typhoid Fever, Especially by Cold Baths, by W. Gilman Thompson; Catarrhal Pneumonia in Children, by F. Forchheimer, M.D.; Angina Pectoris, by William C. Dabney, M.D.; Treatment of Acute Pneumonia, by Sir Dyce Duckworth, M.D., LLD.; Aortic Insufficiency, J. E. Atkinson, M.D.; Examination of the Sputum for Tubercle Bacilli, by Percy Kidd, M.D.,

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Under *Surgery*—Tuberculosis and Excision of the Knee-Joint, by Edmund Andrews, M.D., LL.D.; Pott's Disease of the Spine, by V. P. Gidney, M.D.; Gangrene, by Frederic S. Dennis, M.D.; Fracture of the Skull, by John Ashhurst, Jr., M.D. Under *Gynæcology*—Cancer of the Womb, by Wm. Goodell, M.D.; Removal of the Uterine Appendages, by F. H. Champneys, M.D., F.R.C.P.; Incomplete Miscarriage, by Alex. J. C. Skene, M.D.

These have been jotted down as they have been turned to haphazard, and are given as an illustration of what may be found in this work.

The Students' Quiz Series. Diseases of the Ear, Eye, Throat and Nose. A Manual for Students and Practitioners. By Frank E. Miller, M.D., James P. McEvoy, M.D., and John E. Weeks, M.D. Series edited by Bern B. Gallaudet, M.D. Philadelphia: Lea Brothers & Co. Price $1.00.

Physiology. A Manual for Students and Practitioners. By Frederic E. Manning, Attending Surgeon Manhattan Hospital, New York. Edited by Bern B. Gallaudet, M.D. Philadelphia: Lea Brothers & Co.

These little volumes in the form of questions and answers are based upon the larger text books and are intended as helps in reviewing for the examination room subjects which should have been learned from lectures and the more elaborate text books. They are freely illustrated and the answers generally are in accord with modern teaching, but for the sake of brevity the great essential of quiz-compends, they are greatly condensed and some very important things omitted. The student will do better and learn more if he will take careful notes of his lectures and use these in preparing himself for his examinations.

Climatology of North Carolina.

The above is a title of a publication of 184 pages just issued by the N. C. Agricultural Experiment Station. It embraces all of the meteorilogical records, ever taken in North Carolina from the earliest time to the present. The first record is in 1820 at Chapel Hill and was taken by Dr. Caldwell, prcsident of the University. One hundred and seventy-one separate sets of observations are embodied in the report taken in seventy counties. From the results of these observations it is ascertained that the mean annual temperature of the whole State is 59 degrees, and almost exactly the same as the mean annual temperature of the whole northern hemisphere. The mean annual precipitation is 52.29 inches.

Among the table of contents is included a brief history of the N. C. State Weather Service in co-operation with the U. S. Weather Bureau, a report of work done in 1891, annual summary for 1891, tables of normals for the State, index of all observations made in the State, tables of monthly mean temperature and precipitation at all stations from 1820 to 1892, tornadoes in North Carolina from 1826 to 1892, sketch of the physical geography of the State, a general sketch of the climate of the State.

It is believed that few States have ever issued any publication of such permanent value and interest as the present one, and it shows that North Carolina is fully abreast of the times.

Over One Thousand Prescriptions, or, Favorite Formulæ of Various Authors, Teachers and Practicing Physicians, the whole being carefully indexed and including most of the newer remedies. Price $1.00. The Illustrated Medical Journal Co, Detroit, Michigan.

The title page explains satisfactorily the nature of this volume, and we will only add that there are very many valuable suggestions to be found in its pages, and that each alternate page is left blank that any private formula may be copied thereon aud so be included in the general index.

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Acne and Alopecia. By L. Duncan Bulkley, A.M., M.D., Professor of Diseases of the Skin. New York Post-Graduate School; Physician to the New York Skin and Cancer Hospital, etc. Physician's Leisure Library. $2.50 a year, single copies 25 cents. Geo. S. Davis, Detroit.

These two diseases, which are of such frequent occurrence, and which so often present so many difficulties in their treatment, are discussed in the present little volume in a clear, concise and practical manner.

Diseases of the Kidneys and Bladder. A Text-Book for Students of Medicine. By W. F. McNutt, M.D., M.R.C.S., Ed., L.R.C.P. Ed., Professor of the Principles and Practice of Medicine, University of California, etc. Octavo. Cloth. 248 pages. Philadelphia: J. B. Lippincott & Co. 1893. Price $2.50.

The subject is divided into five sections by the author. Section I. is devoted to the anatomy and physiology of the kidneys, with anolamies of position, form and number. Section II. to the diseases of the kidneys. Section III. to diseases of the pelvis. Section IV. to diseases of the bladder; and Section V. to a discussion of diabetes.

The book is based upon notes of lectures delivered to the students of the University of California, some of which lectures have been revised and enlarged. The nomenclature of kidney diseases, especially the inflammatory varieties, has been simplified as much as possible. The descriptions of the physiology and histology and the various pathological conditions of the kidneys are very clear and will be readily understood by the student, for whom especially the work is intended. The illustrations are not numerous but are very good and serve well to illustrate the text.

Society Reports.

THE BUNBOMBE COUNTY MEDICAL SOCIETY.

This Society met in regular session January 3d, 1893, President Whittington in the chair.

Dr. von Ruck, by request of the Society, read a paper on the Treatment of Pulmonary Tuberculosis Apart from Climate. The author stated that the remedies, if any we have which are of benefit at all, should find employment at climatic resorts as well, climate being by no means a specific or so uniform in the results that having resorted to it we can complacently await the patient's recovery. To show his estimation of remedies he describes their employment in the special institution for phthisical patients under his charge, and believes that the same methods can be carried out in private practice at least to a degree that would assure improvement and cure in a greater number of cases.

Patients at the Winyah Sanitarium are first instructed as to the danger from their expectoration, and receive proper instructions as to its safe disposition. They are warned of the danger from physical and mental over-exertion and are told that while exercise is essential and beneficial it becomes indifferent or a source of danger and a cause for relapses when carried to a degree of sensible fatigue, or when it is taken so rapidly that it produces shortness of breath. Fever is treated by absolute rest and proper diet, and, if necessary, by stimulants and hydropathic applications. Drug anti-pyretics are entirely avoided. The

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diet for fever patients is light, in high fever solid food is entirely avoided; the feeding is frequent and if patients lose flesh under the regimen rectal feeding is resorted to in addition. Patients free from fever receive a generous mixed diet, well cooked, nicely served to the avoidance of pastries and articles of food which in the particular case seem to disagree.

In dilitation of the stomach and severe gastric catarrh lavage and the use of electricity are recommended. Creosote is only given for its influence upon digestive derangements, and the author says it has no specific effect upon the tubercular process, having demonstrated that the germs grow luxuriently in blood serum from patients who are practically saturated by large and long continued doses of creosote, and that the germs from their sputum will produce virulent cultures.

As a general tonic, and to prevent taking cold, every patient receives, before rising, a cold water rub with brisk friction thereafter, and in weak heart he uses strychnine in full doses.

Cough mixtures are never used, the general management being correct there is no indications for them. Local pleurisy is treated by rest and counter-irritation.

Urine analysis is made in all cases where the disease has advanced to destructive changes, amyloid kidney being more frequently found than the text books indicate, and these cases are considered hopeless.

Bloody expectoration is treated by rest and cough then moderated by codeine. Expectoration of clear blood and more decided hemorrhage occurred in less than one per cent. in his institution, and also much less frequently in his private practice since he has learned to appreciate the detrimental effects of over-exertion. He distinguishes the form due to destructive changes and that which results from over-exertion, rest, diet, ice, ergot, morphia, strychnia and astringent inhalations being considered the most useful treatment.

The author still believes in tuberculin, although he is obliged to abandon its more general use in his institution owing to prejudice both of the profession and of patients. He never saw any disagreeable effects, on the contrary he witnessed most satisfactory improvements under its use as advised by him.

The pneumatic cabinet is used in a restricted sense and good results as to better circulation and vital capacity are obtained.

Oxygen and ozone are used frequently in connection with feruginous preparations, when anæmia does not yield to the climatic and other influences.

Plenty of out-door life is recommended both at home and at the resort.

A resolution of thanks to Dr. von Ruck was adopted by the society.

Dr. Fletcher demonstrated a specimen of large uterine, fibroid polypus recently removed by him, the growth having given rise to hemorrhage and being partially protruded from the cervix.

Dr. von Ruck was appointed a committee of one to draft suitable resolutions and to convey them to the family of the recently deceased Dr. Harry S. Williams.

The Society then adjourned.

DR. HARRY S. WILLIAMS.

At the meeting of the Buncombe County Medical Society held at Asheville, January 2d, 1893, the following preamble and resolutions were adopted:

WHEREAS, In the death of Dr. Harry S. Williams the profession has lost a member who gave promise of a most brilliant professional career, and who by his high character and social qualities was esteemed by all who knew him.

Resolved, That we express our realization of the great loss sustained by the profession and the community, and extend to the bereaved family our heartfelt sympathy in their great affliction.

KARL VON RUCK, Committee.

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WM. BAIN HENDERSON, M.D.

Dr. William B. Henderson died at his home, in Rocky Mount, July 3d, 1892. He was born in Gaston county, North Carolina, December 26th, 1861. He received his collegiate education at Davidson College, graduating in the class of 1885. He immediately entered the Medical Department of the University of Maryland, from which he was graduated Doctor of Medicine in 1887.

On returning to North Carolina Dr. Henderson presented himself before the State Board of Medical Examiners at their meeting in Charlotte in April, 1887, and received his license to practice medicine in this State, having stood an excellent examination. At this time he also became a member of the North Carolina Medical Society. After receiving his license, he settled in Mount Holly, where he continued to practice his profession among the residents of his native county and those adjoining until June, 1892, where he was stricken down by an attack of typhoid fever, which proved fatal in three weeks. He was a very successful and popular physician, and his skill and kindness during his short professional career of five years, made him many friends among all classes, who mourn the loss of their faithful physician and valued friend.

Dr. Henderson was married December 17th, 1890, to Miss Louise Dewstoe, of Dubuque, Iowa, and she, with an infant daughter, survives him.

E. M. LITTLEJOHN, M.D.

We chronicle the death of Dr. E. M. Littlejohn, of Thomasville, at the age of twenty-eight. Dr. Littlejohn was born near Louisburg, Franklin county, N. C., and was the son of Gen. Joseph Blount Littlejohn. He graduated with distinction at the Baltimore Medical College in 1885, taking the gold medal.

Current Literature.

THE TREATMENT OF ULCERS BY STRAPPING.

Dr. Charles E. Quimley (*N. Y. Med. Record*) presents the following indications for, and method of, applying adhesive straps in the treatment of chronic ulcers, based upon his experience in the surgical division of Bellevue Hospital. He says:

However valuable or generally available in hospital service recent methods of skin-grafting may be, the chronic ulcer has not yet become a thing solely of historical interest. That it may be cured in most instances in a small fraction of the time required under the common methods of strapping or bandaging I know. I therefore take the liberty of recalling the indications for the use of adhesive straps and pointing out the necessary method of their application to most completely fulfil these indications.

Adhesive straps can fulfil these indications:

1. Approximation of ulcer margins: Thus diminishing the cavity to be filled by granulation, the surface to be covered by cicatrization and the subsequent injury from contraction. Such approximation implies the production of more or less cutaneous tension, and unless such tension is uniform circulation and local nutrition will be impeded. It is impossible to produce even moderately uniform cutaneous tension by the old method of strapping.

2. Compression: Either for absorption of inflammatory exudate and new

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tissue, or to restrain exuberant and prevent fungoid granulations. Such compression also must be uniform and elastic.

3. Support of tissues: Thus favoring circulation and nutrition.

4. Relief of tension and bending in cutaneous border of ulcer. The most important indication, as bearing on local nutrition and the one which common methods of strapping most completely fail to fulfil.

To attain in the most satisfactory manner and degree the foregoing indications the following method of strap ping will be found competent:

1. Adhesive straps should not be over one inch in width, and usually a narrower strap is to be preferred.

2. Straps should be as short as is consistent with a firm hold on healthy skin, and should never fully encircle the limb.

3. All straps should be applied at right angles to the long axis of the ulcer, subject to slight modification by the direction of greatest cutaneous elasticity, and are to be adjusted in two sets.

First set.

4. These straps are applied in the usual manner by fixing one end on healthy skin and approximating the edges of the ulcer as the other end is applied and fixed.

5. The first strap of this set should bisect the ulcerated surface.

6. Each succeeding strap of this set should bisect uncovered ulcerated surfaces.

7. As any strap becomes loosened, one end should be freed and reapplied under appropriate tension.

8. Straps should be applied in this manner until the uncovered strips of ulcerated surface are narrower than the straps in use. The second set is then applied.

Second set.

9. Each strap of this set is to be applied from its centre to both ends simultaneously under appropriate tension, so as to cover an exposed strip of ulcer, and overlap two adjacent straps of the first set. To accomplish this, the straps are held by both ends and adjusted while being firmly stretched.

The degree of tension under which these straps are applied will depend upon the tension under which the first set have been adjusted. If applied under too high tension they will cause puckering of the straps of the first set.

When it is desired to have the tissue compression especially even, it is well so to arrange the first set of straps that the strips of ulcer to be covered by the second set are reduced in width to a narrow line. Even when this is done it is quite as well to use at least a half-inch strap for the second set. When the strapping is completed openings for drainage may be made as necessary.

The essential factors in the foregoing method are:

1. The straps are all applied in the same direction, that of the desired traction, and therefore render their full adhesive value.

2. No two traps are allowed to come in contact until the second set is applied. As the major part of the effect depends upon the first set of straps, this principle of non-contact is of the utmost value. As succeeding straps relieve the strain upon those already adjusted, any loosened strap can be detached and reapplied without disturbing others, and thus each strap made to exert its equable portion of tension and compression.

3. To gain the most even results, this condition of equal strain should be maintained from the outset of the strapping rather than attempted after all the straps of the first set are applied.

The results which can be obtained by careful and intelligent use of the above method are so far superior to those by any other measures as to leave little, if anything, to be desired.

THE SURGICAL TREATMENT OF GENERAL PURULENT PERITONITIS.

After a thorough discussion of the literature and statistics on this subject, Korte, (*Arch. fur klin. Chir.*, Band xliv., Heft 3), comes to the following conclusions: There are but a small number of these cases that can be cured, since, though we may remove the product of suppuration, we cannot, in all cases, find and remove its cause; a prognosis is, therefore, ever difficult and often impossible. Statistics are incomplete, and a true percentage of mortality cannot be deduced. Great progress would result if a distinction were always made be-

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tween cases with and without adhesions. As internal treatment is so absolutely powerless, and death is so certain without surgical interference, abdominal section should always be performed, with the purpose of evacuating and draining the peritoneal cavity.—*American Journal of Medical Sciences.*

THE EARLY EXTIRPATION OF TUMORS.

BY JOHN W. S. GOULEY, M.D.

Most of the following propositions were submitted for discussion and for an expression of the views of members of the New York State Medical Association concerning the metamorphosis of external tumors, the propriety of their excision in an early stage of development, and the contra-indications of operative interference:

1. There is no solid tumor that may not become malignant.

2. Although metamorphosis of benign into malignant tumors seems to be a well-established fact, the precise time of its beginning has not yet been determined.

3. A stage of benignity has been observed in the most malignant tumors. This benign stage is often short, but it sometimes continues many years.

4. Potentially malignant tumors may, with great advantage, be excised during an early period of their benignlty.

5. Exclusive medicinal or local treatment of tumors can be of no service, and may be considered as indirectly harmful by preventing or delaying surgical treatment.

6. It is not necessary to make an accurate differential diagnosis of tumors until after their excision.

7. Accessible morbid growths should be excised as soon as discovered, however small or apparently harmless, because they are worse than useless to the human economy, because of their liability to be transformed into malignant tumors, and because no means are yet known by which to ascertain the exact time of the beginning of metamorphic action.

8. Recurring tumors should be excised as soon and as often as they appear, so long as there is enough tissue for cicatrization. In some cases skin-grafting is of the greatest service.

9. Before excision of a malignant breast-tumor, and the axilla should be cleared of all lymph-glands, and the last part of the operation should be the removal of the breast, together with the surrounding connective tissue and pectoral fascia.

10. Whenever its locality permits, the wound resulting from the excision of a malignant tumor should be seared with the thermo-cautery.

11. "Atrophic" carcinomata should be excised in the beginning of fibrous transformation, but should not be removed when in an advanced stage of sclerous degeneration, particularly when metastasis to internal organs has already occurred.

12. Multiple malignant tumors, as a general rule, should not be removed, especially those that are disseminated over a large extent of the body or those that involve many lymph-glands. When, however, one of these tumors is large and interferes with a vital function, or is in a state of ulceration, it should be excised, if only to give temporary relief.

13. External malignant tumors associated with extensive visceral involvement should not be excised, as the operation would not be likely to prolong life.

14. Ulcerated malignant tumors, causing much pain and exhaustion, should be removed to mitigate suffering, even if the operation prolong life only a short time.

15. In the case of large ulcerated carcinomata, when cutting operations are contra-indicated, soothing lotions and disinfecting cataplasms should be frequently applied, opiates should be administered in sufficient quantity to relieve pain, and deodorizers liberally employed.

16. Bleeding malignant tumors require prompt excision to prevent death from hemorrhage, even though the operation serve to prolong life only a few weeks.

17. Malignant tumors of long bones demand radical measures, such as immediate amputation at a considerable distance from the seat of the disease. If the tumor be in the middle of the leg, the amputation should be at the knee-joint; if in the thigh, the hip-joint exar-

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ticulation would be indicated; if in the forearm, the limb should be removed at the elbow-joint; if in the arm, the limb should be disarticulated at the shoulder-joint.

18. Medicinal treatment, after excision of malignant tumors, should not be ignored, and should consist mainly in the use of reconstituents.

STRYCHNINE IN SURGICAL SHOCK.

In the Address in Medicine before the Mississippi Valley Medical Association, at Cincinnati, October 12, 1892, H A. Hare, of Philadelphia, (*Therapeutic Gazette*), refers to the use of strychnine as a remedy and preventative of surgical shock and anæsthetic collapse, not to speak of its value in opium poisoning, as follows: In these conditions, atropine, while very useful, so far as its vasomotor effects are concerned, does not compare with strychnine either theoretically or practically. To those who habitually employ atropine and morphine injections prior to the use of an anæsthetic, let me recommend the use of strychnine or strychnine and atropine combined. There is one point to be remembered in regard to the use of strychnine in shock or accident, and that is to give it in full doses or leave it alone. Not less than 1-20 grain should be employed hypodermatically every half-hour in an adult, and, if the condition of shock or respiratory and cardiac failure be marked, one dose of as much as 1-5 grain may be given in this way. Disagreeable effects rarely, if ever, follow; and if they do, will amount to little more than muscular twitching, which can readily be governed by sedatives; for if the drug can stimulate the nervous system sufficiently to cause irritability, it will have pulled the patient out of the "Slough of Despond," and he will be able to stand further treatment should the effect of the strychnine be excessive. Under the conditions spoken of, the man is on the brink of death, and we cannot afford to make haste slowly in dragging him back. A few moments lost and he may be beyond reach, and so far over the edge that human aid cannot draw him back to life.—*The Satellite.*

STRONG HYDROGEN PEROXIDE SOLUTIONS LOCALLY IN DIPTHERIA.

Dr. Francis H. Williams, (*Boston Med. and Surg. Journal*), in his usual careful manner, presents a very valuable contribution to our resources in treating this formidable disease. The problems are to kill the bacilli within a few seconds, and to do this without harm to the patient. These conditions fulfilled, it would be necessary to find the means of bringing the peroxide to the vital point, and to preserve the solution. To cleanse the throat merely, and as a gargle, a fifteen volume solution (2.4 per cent.) will answer, but when the membrane is thick and tough, it is necessary to use a solution from fifty to two hundred volumes (8 to 32 per cent.), in order to have it efficient. As soon as the peroxide touches the dead tissues it begins to decompose into oxygen and water, attacking and disintegrating the membrane, and so opening up the way for farther germicidal action. A special atomizer and syringe is designed, the former somewhat resembling the Rumbold spray tube, with which applications can be made as often as required. The syringe can be used for a day or so, from one to three times, and afterward the spray will be generally sufficient. The stability of the solutions varies much, according to their strength; in a cool, dark place, or in a refrigerator, the time of permanency is prolonged. The two hundred volumes will keep for six days in a refrigerator, with a loss of only eight volumes. He summarizes as follows: 1. The peroxide of hydrogen has the unique and necessary quality of disintegrating the membrane, and thus rendering the bacillus accessible. As it only attacks dead organic matter the healthy tissues are not lacerated, as is the case when mechanical means are used to remove the membrane. 2. The peroxide of hydrogen solution is an effective germicide against the bacillus of diphtheria, and is not toxic to the patient. 3. The syringe is simple in construction; it can be kept perfectly clean, and is not attacked by solutions which quickly corrode metals; with it one can easily reach all parts of the throat which are to be seen without a mirror.—*Amer. Jour. of Med. Sciences.*

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AN OBSTETRICAL BUNDLE.

Abbot, Post-Graduate.—This bundle I have found very useful. I have such a bundle prepared for every obstetric case, and its cost, seventy-five cents, is more than made up by the saving of time and subsequent visits. It contains the following:

1. One square yard of rubber cloth to be placed under the patient's hips and thighs—rubber side up of course.

2. One square yard of cotton flannel to be placed on top of the rubber, between it and the patient's body. In this way I make sure of having the bed protected and kept clean, and an aseptic environment, and the rubber can be quickly arranged to carry off the fluids in a suitable receptacle in cases of operative procedures.

3. A number of pieces of cheese cloth to be used as small towels, and also, when dampened with bichloride solution, as pads for the vulva.

4. A new and clean nail brush for each case. The brushes cost three cents and hence one can afford a new one each time.

5. Safety pins.

6. A narrow bobbin, consisting of three strands, for ligating the umbilical cord.

7. An obstetrical eye bandage. This consists of a strip of cheese cloth, the two edges of which are rolled in and then doubled over a second time. While waiting for the pulsation of the cord to cease I wipe out the baby's eyes and wrap this bandage around the head and eyes and pin it. When this is not done the child often rubs its dirty fingers into the eye before attendants have had time to wash the child. Since I have adopted this plan I have never had any cases of opthalmia neanatorium.

8. A small wooden vial containing tablets of bichloride of mercury. I prefer these small ones to the larger size, as they are just sufficient for each dressing without splitting the tablet.—*N. E. Medical Monthly.*

Abstracts.

PHLEGMASIA ALBA DOLERS.—Dr. Barton Cooke Hirst (*Univ. Med. Mag.*), calls attention to the symptoms which occur in milk leg before the actual swelling takes place. He describes these initial symptoms as a fever appearing shortly or immediately after labor of a low grade, but associated with other symptoms of sepsis out of all proportion to the height of the temperature. The pulse is rapid, there is profuse sweating, a dusky flush is on the cheeks, and an indescribable look of anxiety or restlessness is on the face, although in response to inquiries the patient replies with what seems an assumed briskness and cheerfulness that she feels well. There is certainly no pain and, on vaginal examination, no evidence of local inflammation. This may continue from ten days to a month before the leg begins to swell from the ankle up.

As regards treatment he advises absolute rest for the limb, so as to prevent the detachment of an embolus; as much easily assimilated food, chiefly milk, as the patient can digest, and, in bad cases. as much whiskey as she can stand.

THE EXPLORING NEEDLE IN APPENDICITIS.—Dr. Donald MacLean, in discussing a paper on appendicitis, read before the Canada Medical Society (*Montreal Med. Jour.*), calls attention to the danger of the exploring needle or aspirator in the following words: "I think we might almost say now that the aspirator has outlived its usefulness. I have very few cases in abdominal surgery where the aspirator is required. I have seen very sad cases, indeed, where great injury has been done by it. First by the injury it involves; second by sepesis; and third by the incomplete diagnosis. There may be cases where you may empty an abcess by the aspirator successfully, but they are exceedingly rare. They gen erally leave enough behind to insure

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further trouble. At all events, so far as appendicitis is concerned, it is a paltering, palliative and ineffectual mode of dealing with it. Either do one of two things—trust to nature and general treatment, or explore the abdomen and make a thorough, complete and scientific operation."

DURATION OF ANTISYPHILITIC TREATMENT.—Dr. Bontemps (*Merck's Bulletin*) asserts that in no case can the duration of antisyphilitic treatment be fixed at less than three or four years, and has arranged the following table to guide the practitioners:

FIRST YEAR.

6 months of mercurial treatment.
3 months of potassium iodide.
3 months of repose.

SECOND YEAR.

2 months of mercury.
5 months of iodide.
5 months of repose.

THIRD YEAR.

2 months of mercury.
5 months of iodide.
5 months of repose and sulphur baths.

FOURTH YEAR.

No murcury.
Patassium, iodide, with intervals of repose and sulphur baths.

DR. HENRY SMITH (*Brit. Med. Jour.*), reports a case of obstinate vomiting with great debility in an army officer as an sequence of malarial fever. Morphine, hydrocyanic acid, bismuth, oxalate of cerium and most of the other agents reputed as useful wore of no avail. He put the patient on large doses of strychnine with the result that the vomiting ceased in twenty-four hours and was controlled continually and effectually, so that after a few weeks the patient, who was reduced almost to a skeleton, was able to attend to some light duties. He infers that sedatives will control nervous disorders only where nerve tone exists, and that in such cases as this the movements of the stomach are due to a derangement of the centres that preside over the stomach movements, whereby the stimulus of food, which in health excites the physiological rythmic contractions of that organ, in the diseased and irritable condition were sufficient to excite the act of vomiting. Strychnine seemed to establish the physiological tone of these centers and rendor their presiding function steady and co-ordinate.

FOR THE TREATMENT of uncomplicated endometritis and metritis, Dr. J. M. Baldy (*International Med. Mag.*), says he employs the surest and shortest method of procedure. The woman is put under ether, the cervix dilated, and the uterus thoroughly curetted; the uterine cavity is then washed out and an application of Churchill's iodine made to its surface. If the bleeding is too free on account of these manipuiations, the uterus is packed full of iodoform gauze, which is renewed in the course of a day or two. If the bleeding is not alarming it is allowed to continue until it stops of its own accord. The local depletion is one of the things to be aimed at. In the course of a week when the discharge coming from the uterine cavity is little or none at all, ergot may be given, the indications for its use being hemorrhage, or an enlarged, heavy uterus. Usually a half drachm of fluid extract three or four times a day is given for a short time, after which the quantity is gradually reduced, and is finally discontinued in about a week or ten days. Except in the case of hemorrhage it is not well to begin the use of ergot in less than a week as its action will interfere materially with the subsequent drainage; even the hemorrage is best controlled by gauze packing. The dilation is only carried to the extent of making the introduction and manipulation of the instruments easy—say, from three-quarters of an inch to an inch. Great care is taken to make the curettment a thorough one. All debris is washed away with an antiseptic solution. The application of iodine follows immediately with a long-nozzled uterine syringe, the patient returned to bed and nothing more is done for a week or two, except absolute rest, hot-water injections twice daily. and to keep the bowels relaxed. No occasion has been found to place a hard-rubber drain in the uterus as practiced by Wylie nor to pack the womb with gauze for a prolonged period as done by Polk. In this class of patients there is an opportunity for the very nicest judgmeut and skilful

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use of instruments. If one be gentle and skilful, and careful in picking the proper cases, the treatment may be followed by the greatest benefit and no harm.

PHYSIOLOGICAL ALBUMINURIA. — Dr. Henry B. Millard (*N. Y. Med. Jour.*), considers no case of renal albuminuria normal. If it were, it would be more frequent. Unless the microscope is resorted to in determining whether the slightest affection of the mucous membrane exists, the observer is not justified in stating that the albuminuria is of renal origin. Secretions from the bronchial, pharyngeal or nasal mucous membrane, not purulent, but as they occur in an ordinary cold, macerated in distilled water twenty-four hours, heated not to boiling, and filtered has caused non-albuminous urine to respond to the test for albumen. Mucus usually contains in solution organic nitrogenous substances, mucosine, and cells of the mucous membrane from which the mucus is derived. It is in some respects really *albuminous*, and he believes it is this element which in some instances constitutes the so-called "physiological albuminuria."

THE NATURE OF SHOCK AND ALLIED CONDITIONS.—Dr. Wm. C. Dabney, in the *Medical News* of December 3rd, 1892, presents a well digested paper upon this subject. He favors Dr. Mansell Moullin's definition of shock, who says it has of late "become more and more definitely associated with the conception of a sudden check to the circulation brought about through the agency of the nervous system, and resulting either in a death so immediate as to scarcely have a parallel, or in a condition of prolonged prostration, with or without more or less successful reaction." In considering the symptoms, besides the pallor, faintness, rapid and feeble pulse, cool and clammy skin, etc., he calls attention to the intestinal tympanites, which is sometimes present, especially in cases of railway injury. He attributes this symptom to loss of tone of the muscular coat of the bowel, due to the defective nervous action, and which he thinks very suggestive as to the pathology of many cases of shock.

In speaking of the circumstances under which it may occur he mentions blows upon the abdomen, the ingestion, when overheated, of large quantities of ice-water, the rapid withdrawal of large quantities of fluid in cases of ascites and operation upon the abdominal viscera. He thinks the difference between shock and syncope one of degree only, and that the nature of shock is explained better by the dilatation of the large blood-vessels, especially of the abdominal cavity than by any other view, though it is probable that in most, if not all cases, there is a reflex paresis of the vagus as well. While it is not probable that, under ordinary conditions, these vessels are capable of sufficient dilatation to cause death it may be the case where the vessels have become enlarged and more numerous, perhaps, as in cases of ascites or pregnancy. As a striking evidence that shock may be due to dilatation of the abdominal vessels, he cites the rapid respond in cases of shock during abdominal operations, to a flushing of the cavity with hot water, which by contracting the abdominal vessels throws more blood into the general circulation.

He concludes:—

1 Shock is not due to a spasm of heart or vessels.

2. It is often due to a paresis of the vagus nerve, caused either (1) *directly* by emotions, severe jars, etc., or (2) by reflex influence from injuries of other nerves (certain poisons by *direct* action also cause symptoms much like those of shock).

3. It is questionable if shock is ever due to the inhibitory action of the vagus on the heart's action, but possibly some cases of sudden death from shock may be explained in this way.

4. In many cases shock is due to the dilatation of the vessels in the abdominal cavity, which is often accompanied by a paresis of the vagus nerve.

OXY-CHLOROFORMIC ANÆTHESIA. — Nicholson (*Brit. Med. Jour.*), acting on the declaration of the Hyderabad Chloroform Commission, that the cause of death from chloroform is due to an "overdose," and "asphyxia" has sought a remedy, and believes he has found one in oxygen. It is administered in combination with the chloroform vapor by means of what he terms an "oxy-chloro-

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form inhaler," so constructed as to bring the two agents under the control of the manipulator. A judicious combination of oxygen and chloroform keeps up the blood pressure, maintains regularity of the respiration, and ensures perfect aeration throughout the period of administration; it limits the action of the chloroform to the suspension of consciousness, does away with much of the post-anæothescial depression, brings about a much more rapid recovery from the anæsthetic, and induces a feeling of confidence unknown under the old system, because by it the "accidental" feature is eliminated.

TREATMENT OF SORE NIPPLES.—Dr. P. F. Ellis (*Med. and Surg. Reporter*) contributed a paper on this subject to the North Texas Association, in which he presents some ideas of etiology and treatment which are original and interesting. The cylindrical lactiferous ducts just before reaching the base of the nipple are enlarged perceptibly, forming ampullæ. At the outer end of the ampullæ there is quite a narrowing of the tube, and many are bent to a greater or less angle, and then have a straight course to their respective openings in the extremity of the nipple. A constriction at this angle preventing the contents from flowing through, causes distension of the ampullæ with final suppuration. This condition of constriction may be suspected when the child has to suck so hard as to cause the mother pain, with tender chords or lumps in the breast. The suppuration may be aborted at this stage by passing a fine probe through each opening in the nipple and into the ampullæ. The nipple is squeezed gently, when the fifteen or twenty openings for the corresponding tubes are brought into view, the operator being supplied with a watchmaker's magnifying glass. When the fine probe has been passed through the strictured tube or tubes, introduce a blunt probe of larger size and more fully dilate the stricture, and the case is cured at once. The operation can be done in fifteen minutes, without an anæsthetic, and is eminently satisfactory to patient and physician. The author has never seen a case of fissured or raw nipples except in those women having pink-colored nipples—never in the negro or Indian, or where the areolar tissue was darkly pigmented.

BARKER'S METHOD FOR FRACTURE OF THE PATELLA.—Drs. J. William White and Alfred C. Wood (*Amer. Jour. Med. Sciences*) report a case of fracture of the patella in a man, aged twenty-three years, treated by Barker's method for fixing the fragments. The operation is as follows: The lower fragment being held firmly, an opening is made into the joint, with a narrow-bladed knife, its edge toward the patella. The opening is made through the ligamentum patellæ. A long pedicle needle is then passed through this opening, behind both fragments of bone, and hugging them as closely as possible. The upper fragment is then held firmly and the needle passed through the tendon of the quadriceps. The skin is then incised over the point of the needle, which is threaded with sterilized silk or wire and withdrawn, thus carrying the thread behind the fragments. The needle is then unthreaded and passed through the same skin wounds from below, but close to, and in front of, the fragments. It is then threaded with the upper end of the suture and withdrawn, thus having both fragments encircled by the thread, with its two ends projecting from the lower skin wound. Friction is then used to remove clots from between the fragments of bone, and the suture firmly tied. The ends are cut close and the skin wounds closed. In the case reported passive motion was begun on the tenth day, the patient out of bed on the thirteenth day, walking without much difficulty, and he left the hospital at the end of three weeks, with a very useful knee. At the time of this report, ten months after, the range of motion and general usefulness were as good as on the other side.

ALTITUDE IN AFFECTIONS OF THE HEART.—Dr. Frederick I. Knight presented the following propositions before the American Climatological Association:

1. In cases of valvular disease with sufficient cardiac enlargement or derangement of the circulation to make the diagnosis certain, it is safer to forbid the chance of a failure of compensation

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through decreased atmospheric pressure in a change from a low to a high altitude of from four to six thousand feet.

2. Cases of chronic myocarditis, or fatty degeneration should be rigidly excluded. These are the cases among which there is such sudden fatality from apparently slight variations from a dull routine of life. There may have been symptoms calling attention to the heart, or there may not have been, or the symptoms may have been misinterpreted, as, *e. g.*, calling an attack of angina pectoris "gastralgia." A careful examination of the area of cardiac dulness should be made. A very valvular first sound, an almost entire loss of the booming or muscular quality, with a weak and irregular pulse in a man no longer young, especially in connection with subjective symptoms, breathlessness on slight exertion, are strong confirmatory signs.

3. Patients with systolic murmurs, which are known to have existed many years without any enlargement of the heart, or any alteration of its normal sounds, and who present, on physical examination, no other evidence of disease, may be allowed to go into high altitudes.

4. In cases of nervous palpitation due to errors in diet and mode of life, when these errors have been corrected, of course the patients may go into a higher altitude.

Affections of this kind due to some morbid condition of the nervous centers, may be divided into two classes—those inheriting a nervous temperament, and those nervous from malnutrition. The latter would be apt to be improved, but the former made worse by a change to a higher altitude.—*International Medical Magazine.*

ASAPROL has been studied by M. Auguste Bompard with the following result: 1. It is a whitish, odorless, bitter powder; soluble in three parts of distilled water, and in alcohol less soluble. About one-half the amount ingested is eliminated by the kidneys, more if administered in cachets. 2. It is a good genersl antiseptic; in 2 per cent. solution it retards the development of the bacilli of Asiatic cholera, herpes tonsurans and typhoid fever, a 3 per cent. solution completely arresting the two first named. 3 It is a good antipyretic, its effects being manifest, rapid and persistent. 4. It possesses marked analgesic properties, in the last two properties being superior to antipyrine and quinine in influenza, adminstered consecutively or combined. 5. It is a remedy of choice in acute articular rheumatism, administered in *cachets*, in daily does of from fifteen to sixty grains, requiring but two days to demonstrate a marked amelioration of the symptoms. Its action is quite as rapid as that of the salicylates, and relief is well marked, usually upon the second day, and becomes constantly more marked, and, on the average, cure results in eight days. It is even more certain than the salicylates, no failnre being recorded, while in about 22 per cent. of the cases in which the salicylates were employed failures occur. Although the taste is bitter, it does not give rise to nausea or vomiting, and the auditory disturbances cerebral congestion (of old age) are absent. It is efficient in less than one-half the dose of salicylates—in fine it yields in no respect to them, and in certain cases it is superior, in that it presents none of their inconveniences. The normal dose by the mouth is sixty grains a day, preferably in small frequent doses that its effect may be continuous. Begin with thirty grains the first day, the next forty-five, and the succeeding days, the full amount of sixty grains is needed, continued, if needed, several weeks, terminating the treatment by gradually reducing the daily dose. It can be given in distilled water, or in syrup and anise seed water, or in *cachets*, or as an excellent gargle, in mulberry syrup and in infusion of blackberry leaves. Being a lime salt it is incompatible with all salts that precipitate lime, notably the soluble sulphates and bicarbonate of soda. Iodide of potassium is absolutely incompatible with it. 6. It favorably modifies the anginas and the infectious condition in pneumonia.—*American Journal of Medical Sciences.*

THE TREATMENT OF HEMORRHOIDS.—The treatment of hemorrhoids was discussed by Dr. John B. Weaver before the Philadelphia County Medical Society (*Maryland Med. Jour.*). He reminds his readers of the anatomy of the hemorrhoidal veins, the superior emtying into the portal vein and the middle and in-

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ferior into the general venous system. He classes internal hemorrhoids, which protrude at stool and can be replaced and retained within the spincter, as a disease of the portal system as they involve the superior hemorrhoidal vessels. External hemorrhoids occur in three forms—a simple venous tumor, the result of phlebitis and consequent thrombosis of a varicose vein; second a tumor composed of dilated and varicos veins with proliferation of the surrounding connective tissues; and third a tumor made up entirely of proliferated connective tissues. Intero-external hemorrhoids consist of both the above varieties.

In regard to palliative treatment he thinks the most important indications to be fulfilled are daily evacuations of the bowels with strict attention to cleanliness. In some instances one of the various astringent ointments may be of service, but he has little faith in them as curative agents.

As hemorrhoids may be symptomatic of visceral diseases, of structural changes in the rectum above the pile bearing area, such as carcinoma, stricture, etc., these should be searched for before proceeding to radical treatment, and corrected if possible.

In the first form of the external variety it will suffice to incise the tumor freely and turn out the clot, then pack the wound gently. In the second form it is often snfficient to stretch the sphinc ter muscle, if not the tumor should be removed with the clamp and cautery. The third variety should be removed with the clamp and cautery.

Of the numerous operations devised for the cure of internal hemorrhoids he has had experience with the clamp and cautery, ligature, injection of carbolic acid, Whitehead's, and dilatation of the sphincter muscle; but he now rarely does any other than the clamp and cautery. The advantage of this method is its universal application. The instruments necessary to perform it are a pair of Smith's clamps and a pair of pile forceps a pair of scissors, and a Paquelin's cautery. Tue sphincster is dilated, when the piles protrude and are grasped with the forceps and the clamp adjusted. The pile is trimmed off with the scissors, leaving a stump a quarter of an inch above the clamp. The cautery is heated to a dull red and the stump reduced with it about one-half leaving a charred dry surface. The clamp is removed and the edges of the stump allowed to fold in. By leaving a pedicle as described bleeding cannot follow the removal of the clamp. In cases where the pile surface is mucocutaneous, before the clamp is adjusted the skin should be divided with a pair of scissors to prevent pain and subsequent contractiou. The subsequent treatment is an opium suppository, dusting the surface with iodoform and the application of an antiseptic dressing. The after treatment consists of rest in bed, light diet, and the administration of a quarter of a grain of opium pill night and morning for from three to four days, when the bowels are moved by a laxative and an enema given when the desire to defecate is felt. After this the patient is allowed the freedom of the room. The advantages of this operation are freedom from hemorrhage, the rapidity with which it is performed, the absence of pain in the majority of cases, the absence of retention of urine, and the patient's being able to resume his or her occupation in from a week to ten days.

Notes of Practice.

Puerperal mastitis is often successfully aborted by prompt and energetic treatment with compresses steeped in hot water, in each quart of which one ounce of carbonate of ammonia has been dissolved.

Sodium salicylate always gives satisfactory results in the treatment of sprains. Administered in 15-grain doses, four times daily, the attendant pains rapidly cease and massage can generally be commenced on the second day.

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The most palatable method of administering pure cod-liver oil is in equal parts of lime water.

Sulphonal, which has proved such a failure in the hands of many practitioners as a remedy in the delirium of alcoholic patients, is now heartily endorsed as a great analgesic agent in relieving and arresting the cramps of fractured limbs and other reflex spasms.

Spontaneous hemorrhages that are recurrent, and whose causes are not easily discoverable, but are presumably due to diseased conditions of the liver, spleen or kidneys, are oftentimes speedily arrested by more or less revulsive treatment by means of blisters over either or all of these regions.

In vomiting of pure gastric origin, a 20 p. c. solution of menthol in olive oil acts promptly and efficiently, and better fulfils the indications than any single remedy now known. It should be given in ten-drop doses on finely-powdered sugar, and should be exhibited just prior to the expected attack of emesis.

Viburnum prunifolium constitutes an excellent means of treating mechanical dysmenorrhœa in virgins. To obtain the best results, the treatment should be instituted ten days at least before the expected flow, and the medicament should be exhibited in twenty-five drop doses of the fluid extract, four times daily, and continuing till the end of the catamenial period.

In the uncontrollable vomiting of pregnance, especially when the secretions are excessively acid, gratifying results are often obtained by the administration of three grains of sodium chloride in a teaspoonful of chloroform water, frequently repeated. This combination has been successful in eleven cases where many other remedies had failed to give even temporary relief.

A French surgeon is employing collodium in the treatment of erysipelas with marked success. He paints around the affected surfaces a broad band, and in cases of erysiplas of the extremities, he paints a streak about the breadth of two hands. Beyond this, the disease never spreads, and improvement is noticeable usually on the second day. This method is also applicable to facial erysipelas.

The best food substance for use as a nutritive enema is said to be raw egg with common salt, which is used to dissolve the albumen, in the proportion of fifteen grains of the latter to each egg. The eggs, thus prepared, should be thoroughly beaten and then injected slowly through a rubber tnbe high np in the bowels. Care should be taken to empty the bowels one hour previous to the employment of the nutritive enema by lavements with tepid water, none of which should be allowed to remain. Eight eggs in twenty-four hours will be a sufficient quantity.

In the persistent diarrhæas sometimes attendant upon fevers of a remittent character and of a long continued type, Mr. Harold Henly (*London Practitioner*), warmly commends the use of digitalis and strychnine. The former is indicated from its well-known action upon the vasomotor system, and the latter from its supposed direct action upon that portion of the system controlling the blood supply to the intestine. The mixture he employed is composed of tinct. digitalis ℥jv; liq. strychninæ ℥ij; spts. chloroformi ℥v; in water, and repeat at from one to four hour intervals as required.

Large doses of cream of tartar in the treatment of ascites due to hepatic cirrhosis or simple chronic peritonitis is highly recommended by Dr. Sasaki and other Japanese physicians. Under this remedy, the ascites, when due to these causes, rapidly snbsided and disappeared

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in some cases not to return for two years. In one instance it was successful after all the other remedies, calomel, digitalis, diuretics, etc., had failed and after the patient had been tapped twenty-eight times. He administers the acid tartrate of potash in the beginning of the treatment in 3 ij doses daily, and gradually increases the quantity to ʒ j each day, according to indications. Tonics and nourishing food are necessary adjuvants.

Dr. Charles S. Morley (*N. Y. Medical Journal*), claims that anæsthesia can be produced and maintained for one or two hours with from one to three drachms of chloroform. His method of procedure is to have an assistant bare the chest and note only the breathing, care being exercised to have it rythmical. This is accomplished by covering up the face with a handkerchief, pulling up a fold at the center for an air space for the chloroform vapor and dropping one drop at a time and not more than two to five to the minute. The quantity is regulated according to the breathing, and thus the minimum of quantity is employed while the maximum of effect is reached and maintained.

Dr. G. P. Field (*Brit. Med. Jour.*) says that in the acute aural catarrh of young children—of which one sign is the refusal to rest the head on the affected side—poultices should be avoided, as they only promote suppuration; pain is best relieved by the frequent fomentation of the external meatus with water. Mild purgation and politzerisation are also of assistance. By the timely use of the latter many an earache might be completely prevented, as it renders the Eustachian tube pervious and equalizes the pressure on the drum-head. Until pain has subsided, warm water should be poured into the ear, and syringing and the use of stimulating lotions are to be shunned. Afterwards weak and soothing lotions, such as solution of acetate of lead and tincture of opium, may be resorted to. Perchloride of iron and silver nitrate are unsuitable for acute cases. Powdered boracic acid, or occasionally alum, may be very efficacious, but the insufflation of powders is not to be recommended except in chronic cases where there is a large perforation.

SELECTED FORMULÆ.

Whooping-Cough.

℞—Ext. scutellariæ, fl..... 3 ij
Ammonii chloridi,
Pulv. cinchonæ rubræ,
Spts. ammon. arom., aa 3 i
Spts. gaultheriæ..... ♏xv
Spts. frumenti opt..... ʒ i
Mel. despumati..... 3 iv
Aquæ, q. s., ad..... ʒ iv
M. S.—Give from 15 drops to 3 ij, according to age, four times daily.—*Dr. R. S. Patterson in Times and Register.*

Anti-asthmatic fumigation.

℞—Stramonium leaves
Green tea..... aa parts 24
Lobelia inflata.... " 9
Mix, and moisten with a saturated solution of nitrite of potash; dry, and keep in well stoppered bottle. A teaspoonful is sufficient for one fumigation. —*Plant, Ex.—N. E. Med. Monthly.*

For chapped hands.

℞—Menthol.....gr. iij
Salol.....gr. vj
Ol. olivæ..... 3 i
Lanolini..... 3 iij—M.
S. Apply topically once or twice daily.—*L'Union Med.—Med. News.*

Typhoid Fever.

℞—Methyleni bichloridi.... 3 i
Sol. hydrogenii peroxid.,
(10 volumes)..... ʒ i
Acidi hydrochlor. dil... ♏xxx
Aquæ distillatæ, ad... ʒ vj—M.
S. A twelfth part in half a tumbler of pure water every 3 hours as directed.

This mixture may be used by the patient as a simple drink, or by enema. Under its action the tongue becomes clean and the pyrexia falls.—*Richardson in Epit. of Med.*

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Miscellaneous Items.

Under this head space will be given, free of cost, to those *paid-up* subscribers who desire to change their location, or to dispose of practice or property. One insertion will be allowed, but inquiries must not be ordered addressed to this office.

Any news connected with professional men and matters in North and South Carolina will be appreciated by the Editors.

Dr. A. Cheatham has removed from Henderson to Durham, N. C., where he willpractice his profession.

Dr. E. R. Michaux, of Greensboro, has received the appointment of Assistant Surgeon of the Third Regiment, N. C. S. G.

Correction.—The article on page 35 of this issue should be credited to the *Medical News*. In section 9 of said article, second line, omit *and*.

Dr. Joseph M. Meggett, an ex-Confederate surgeon, committed suicide in Charleston, S. C., by shooting himself in the head while temporarily insane.

Dr. J. M. Hays, of Oxford, who filled the office of Secretary of the State Society for several years, has been appointed surgeon of the Second Regiment, N. C. S. G.

Dr. Samuel Logan, a prominent physician of New Orleans, died of apoplexy in that city on January 12th, his wife having died only three days previously. Dr. Logan was a native of Charleston, S. C.

In our notice of Gould's Pocket Medical Dictionary, in our last, the types made us give the size 3½x3 inches. We wrote 3½x6 inches, and since the shape of this handy little companion is a great point in its favor, we beg that our readers will take note of this correction.

Dr. R. J. Brevard, Mayor of the city of Charlotte, received a fracture of the neck of the femur through a fall upon the ice a few days since. The Doctor has the sympathy of the JOURNAL and other friends, in his serious injury with their wishes for his early restoration to health and active usefulness.

New York city has adopted an ordinance giving physicians holding a police permit the right of way in the streets with the right to cross processions as soon as possible when answering calls for their services. The permit is granted to any duly registered physician and is not transferable.

We regret to learn of the idisposition of Dr. Robert Battey. He has gone to Florida to recruit his health and we trust the change and respite from professional cares may be speedily beneficial.

The *Abstract of Sanitary Reports* for December 10th in giving a list of ports ann places from which the importotion of rags is absolutely prohibited, shows Hamburg to be excepted, while official reports show the constant occurrence of new cases in that city.

Health Conference.—The State Board of Health has been called by President Bahnson to meet in special session in the city of Raleigh on Tuesday, January 24th, hour and place to be given in that morning's paper. It will consider particularly: 1. Our present health laws, with a view to amendment by the General Assembly. 2. The threatened invasion of Asiatic cholera, which is regarded as more than probable next spring or summer, and the best means

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of keeping it out of our State. 3. The salaries of County Superintendents of Health. And, generally, any subject relating to the public health that may be introduced.

McCaskey's Clinical Studies is published quarterly at Fort Wayne, Indiana, with uncut leaves. The contents is made up of abstracts from the clinical notes of G. W. McCaskey, A.M., M.D., Professor of Practice of Medicine and Diseases of Chest and Nervous Diseases in the Fort Wayne College of Medicine, with some book reviews.

The *Medical and Surgical Observer* is a new monthly journal edited and published in Jackson, Tenn., by M. Vandahurst Lynk, M.D. It is, as far as we know, the first medical journal in this country to be published by and for the negro profession. The "initial number" is very creditable and we hope the enterprising editor will receive the support of his professional brethren.

This issue of the JOURNAL is somewhat delayed on account of having to wait for new type which got off the track *en route* and had to be traced, but our readers may confidently expect their JOURNAL within a day or two after the *fifteenth* of each month as we have a contract with the publishers for it to be delivered for mailing on that date, the contract providing for a forfeit in case of failure to so deliver it.

Before the Johns Hopkin's Hospital Medical Society November 7th, 1892. Dr. Finney presented a man who, nearly three years ago, had the ends of two fingers cut off by a knife used for cutting tin. He reported to the hospital seven hours after the accident, bringing the ends of the fingers wrapped in a paper in his pocket. One finger was cut off at the root of the nail and the other nearer to the last joint. With no hope of getting union he soaked the amuputated ends in warm water and cleaned the wounds with bichloride 1-2000. The ends were then applied and retained by four sutures to each. There was union by first intention in both fingers and when presented there was sensation in the tips of both, and hardly a mark to show the line of union.—*Johns Hopkins Hospital Bulletin.*

A New Professorship in the Jefferson College.—At a meeting of the Board of Trustees held on Wednesday, November 30th, 1892, Dr. G. E. de Schweinitz was, on the unanimous recommendation of the faculty, elected Clinical Professor of Ophthalmology in the Jefferson Medical College. At the time of election Dr. de Schweinitz was Professor of Ophthalmology in the Philadelphia Polyclinic and lecturer on Medical Ophthalmoscopy in the University of Pennsylvania.

A case of hydrophobia five years after being bitten is reported in the *British Medical Journal.* The patient with his brother and a neighbor were bitten by a mad fox terrier on August 1st, 1887, and the three were treated by Pasteur, remaining under treatment from August 5th to 19th. The brother of the patient was seized with hybrophobia the following October, dying the next day. This patient was a lad, aged 17. He was taken sick with symptoms of hydrophobia September 4th, 1892, the symptoms becoming very severe and proving fatal in forty-eight hours.

Dr. J. Allison Hodges, of Fayetteville, will remove to Wilmington about February 15th next, where he will practice his profession and enter actively upon his work as one of the editors of the JOURNAL. Indeed, Dr. Hodges has not been idle as he is now situated, much interesting matter in this number being from his pen. The profession of a town

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can only be honored by the addition of a physician of such high social and professional standing as Dr. Hodges enjoys, and we assure him a most sincere welcome. In social circles the Doctor and his estimable and accomplished lady are far from being strangers in Wilmington, and will be given a hearty reception at the hands of their many acquaintances.

Our venerable and esteemed friend, Dr. E. A. Anderson, celebrated his Golden Wedding on the 24th of December last. Since the death of Dr. Satchwell Dr. Anderson's name stands seventh on the Society's roll, he having signed the constitution in 1852. The Doctor still continues to do some practice, and in the past few years, by private stdy has made himself able to read French and German fluently, and is at present engaged in the study of Spanish. The JOURNAL extends the Doctor and his excellent wife its congratulations and heart felt wishes for health and happiness during the coming year.

A quarantine bill has passed the Senate which is far from satisfactory, and it is hoped that it will not pass the House. While Congress is dallying over this important matter spring is approaching, and there should be no time lost in preparing for war against cholera, which has only gone into winter quarters. We await with much interest the result of the meeting of the State Board of Health on the 24th, and trust this Legislature will be wise enough to put the quarantine station of the Cape Fear, the gate through which epidemic disease is most likely to get into North Carolina, in a condition to care for, and thoroughly disinfect and purify, any vessel that may bring the disease in crew or cargo.

Arkansas has been in alarm concerning an outbreak among the convicts in a penitentiary camp at Helena in that State. The disease was characterized by violent purging and vomiting, quick collapse and great muscular pains and soreness, in some cases taking the form of cramps of the lower limbs. Dr. Robertson, the penitentiary physician, states that of 100 convicts in camp, he was called upon to treat at least 75, and of these 18 died. This was after the return of the convicts to the penitentiary, and the deaths included three who had never left the walls. Dr. H. D. Geddings, Passed Assistant Surgeon, M. H. S., was sent to Helena to investigate the nature of the disease, which was feared to be cholera. The expert bacteriologist, who was also sent, could discover no cholera bacilli in the dejections, and Dr. Geddings attributes the disease to the filthy and extremely unsanitary condition of the camp. The food furnished, while insufficient in quantity, was of the coarsest, commonest quality, and the water for cooking and drinking was drawn from a ditch, canal or branch, which receives the sewage, in part, of the city of Helena, and which is further contaminated by the proximity of two long-used slaughter-houses, and an extensive surface of saw-dust, rotten from damp and over flow. The convicts were housed in box-cars, 18 or 19 to each car, with no ventilation. It is not to be wondered at that these conditions gave rise to a form of gastro-enteritis violent enough to simulate Asiatic cholera in its symptoms.

Soothing syrup without opium.

℞—Oil anise..... ♏xxv
Alcohol..... ℥ ij
Fl. ext. valerian..... ℥ i
Oil peppermint..... ♏xv
Tinc. camphor..... 3 ij
Fl. ext. liquorice..... ℥ i

M. Sig.—Shake the bottle. Dose, one-fourth or one-half teaspoonful in water; repeat as needed.—*Chas. S. Cope, M.D.—Med. Age.*

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Reading Notices.

EPILEPSY.—Hammond, Lauder. Brunton and Allen McLane Hamilton, all declare the Bromides of Potassum, Sodium, Ammonium and the Bromide of Zinc "stand pre-eminent among the remedies for Epilepsy." Neurosine contains only the C. P. Bromides and can be given indefinitely without deranging digestion.

We call the attention of our readers to the advertisement of the Robinson-Pettet Co., Louisville, Ky., which will be found on another page of this issue. This house was established fifty years ago, and enjoys a widespread reputation as manufacturers of high character. We do not hesitate to endorse their preparations as being all they claim for them.

R. W. St. Clair, M.D., Brooklyn, N. Y., says: I have used S. H. Kennedy's Extract of Pinus Canadenis for two years, in a large practice, and so far have never failed in reaching the most happy results. One case of nasal catarrh that resisted the best treatment of some of our best practitioners, came to me. I began with the Pinus Canadensis, and am pleased to say the cure is absolute. In two cases of diphtheria I used Pinus Canadensis, 1 ounce to one-half pint of water, with the best results. The membrane peeled off and no new formed.

It may interest you to know that I have had a most satisfactory result from the administration of your BROMIDIA in a case of sleeplessness, after a slight apoplexy, with partial paralysis of the right cheek and arm. The patient (male, 63 years old) suffered from weak heart, and before coming under my care had been given Sulphonal, Paraldehyde, etc., without sleep being obtained. The first night here he received one drachm of Bromidia and got seven to eight hours quiet sleep without any ill after-effect from the drug. The same dose continues to give the patient some hours' sleep every night.

E. L. Fish, M.D., West Valley, N. Y., says: I can heartily endorse Aletris Cordial after giving it a fair trial. Mrs. F——; aged 27, mother of two children, during the last seven years has miscarried three times. Has lateral curvature of the spine, and never robust Began in her last gestation, at four months, to give Alertris cordial, three-fourth teaspoonful three times a day, and increased to one teaspoonful, She has used four and one-half bottles, and is now within four or five days of full term. Her general health has been much improved, appetite good, no vomiting, bowels in good condition, and kidneys acting well. I am exceedingly well pleased with the action of the remedy, as is also my patient.

Among recent additions to the list of Parke, Davis & Co., whose constant endeavor is to add to and improve their manufactures, are the following: Fluid extract of Cocillana, the Bolivian remedy for respiratory inflammations. Compressed tablets of Calomel and Sodium and Bicarbonate, 2½ grains each. Tablet triturates of ext. Cascara Sagrada, 1 grain. Antiseptic tablets, ℞ "C." Gelatin-coated pills—Terpine Hydrate, 5 grains; also Strychnine Nitrate, 1-40 grain. Pill of Aloes and Iron, No. 797, ℞ "A," half-strength. Normal liquid Golden-seal. Improved Bronchial Lozenges. They also now prepare Liquid Extract Cascara Sagrada, B. P.; Fluid Aloes Co. for dec. aloes co., B. P.; Fluid Sarsa. Co. for dec. sarsa. co., B. P.; Fluid Gentian Co. for inf. gentian co., B. P.; Fluid Rhei for tinct. rhei, B. P.

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INGLUVIN.

A POWDER:—PRESCRIBED IN SAME MANNER, DOSES AND COMBINATIONS AS PEPSIN; USED IN ALL CASES WHERE PEPSIN IS PRESCRIBED WITH GREATER ADVANTAGE

A SPECIFIC IN VOMITING OF PREGNANCY.

IN DOSES OF 10 TO 20 GRAINS.

Opinions from Physicians Respecting its Efficacy.

INGLUVIN in SPAIN.—The following letter on Ingluvin was recently received by Vilanova, Hermanas & Co., of Barcelona, from DR. F. VIDAL SOLARES:—

"I have to acknowledge duly having received the Ingluvin which you were good enough to send me for the purpose of proving the therapeutic effects of this excellent medicine amongst my clients, from Messrs Wm. R. Warner & Co.

The results which I have obtained in my dispensary for sick children, together with my private cases, have been extremely satisfactory. In fact, I have treated various cases of dyspepsia, in which the patients, fully prostrated and without power to digest their food, have, thanks to the use of Ingluvin, been rapidly cured.

In the case of 'apepsia,' or loss of appetite, in children, accompanied with diarrhœa, I have obtained good results from the use of Ingluvin, which therapeutic agent is extracted by the house of Warner & Co., from the stomach of the chicken.

I have found Ingluvin useful in the organic complaints of the stomach, and in the indomitable vomiting and painful dyspepsia to which women are subject during pregnancy. I have employed the agent, moreover, in the convalescent state of many patients, when I have not only noted the alteration of the gastric secretions, but of the extreme instability of the stomach,

I have not the least doubt that the Ingluvin, of which you have the sale in Spain, will in a short time become a substitute for pepsin on account of its being more active than the latter; but, as is only logical, you should obtain a rapid result by bringing this preparation to be known in all Spain by the opportune measure you usually adopt.

Hoping you will have the justice to manifest to the manufacturer the results I have obtained in my practice with Ingluvin, I am,

Respectfully, F. VIDAL SOLARES, M. D.

A SPECIFIC IN VOMITING IN PREGNANCY.

Drugs and Digestion.—The discussion of a paper with this title, read by Dr. R. G. EOCLES at a previous meeting (see vol. xliv, page 600), was now taken up

Dr. P. H KRETZSCHMAR said that he had made some investigations of the same subject several years before, and had arrived at some of the reader's conclusions.

Dr. ARNOLD STUB fully coincided with Dr. Kretzschmar as to the value of the Pharmacopœia as a guide both for apothecaries and for physicians. He knew little of Ingluvin, and less of what became of it after it entered the stomach, but he had prescribed it for the vomiting of pregnancy, and it had checked it after everything else had failed; consequently, he should continue to use it in such cases, and perhaps in those cases only. *New York Medical Journal.*

MESSRS WM. R. WARNER & Co. London, W., November 29th, 1889.

Gentlemen:—I have tried your Ingluvin in a case of vomiting in pregnancy with the greatest success, and I have found it altogether a very useful preparation.

yours faithfully, ARTHUR H. WOOD, L.R.C.P., L.R.C.S.L.F.P.S.

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ERGOTOLE S & D's

is a Concentrated (2½ grs. of select Spanish Ergot to each minim)
Purified (all inert and irritating matter is removed)
Permanent (it *keeps* perfectly without deterioration)
Preparation of Ergot that

Does not Produce Nausea

when given by the mouth, and does not produce irritation or abscess when exhibited *hypodermically*.

We will send samples and literature.

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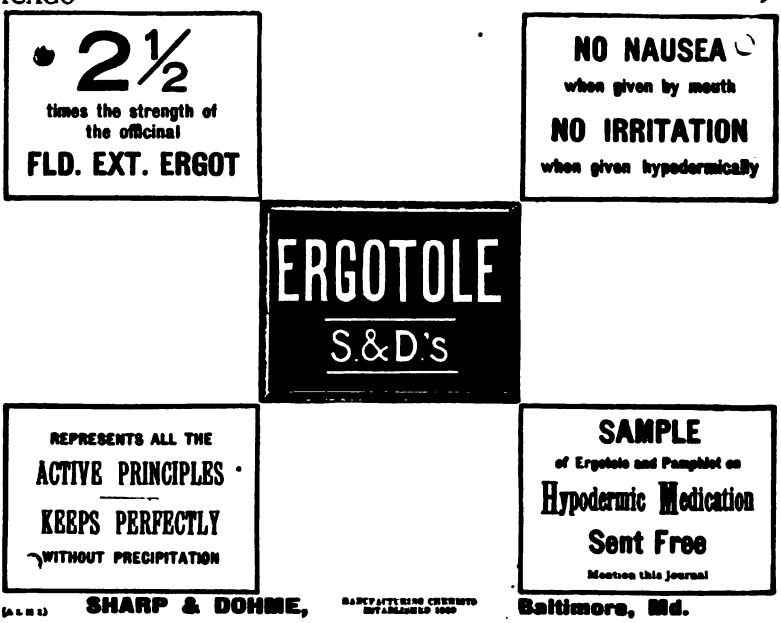

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Note Relative to the Buffalo Lithia Water.

WM. A. HAMMOND, M.D., WASHINGTON, D. C.,

Surgeon-General U. S. Army (retired) formerly Professor of Diseases of the Mind and Nervous System in the University of New York, etc.

There is a point in relation to the therapeutical efficacy of the Buffalo Lithia Water which has not as yet, I think, received sufficient attention. It is well known that many cases of diseases of the nervous system are complicated with lithæmia, and that unless this condition is removed a cure is very often retarded and not infrequently prevented. It is quite commonly the case that in cerebral congestion producing insomnia, nervous prostration, resulting from over-mental work of much emotional disturbance, and in epilepsy (to say nothing of many cases of insanity,) an excess of uric acid in the blood is often observed. This state appears to be altogether independent of the character of the food, for no matter how careful the physician may be in regard to the diet of his patient, the lithæmic condition continnes. I have tried to overcome this persistence by the use of phosphate of ammonia and other so-called solvents for uric acid, but without notable effect.

Several years ago, however, I began to treat such cases with Buffalo Lithia Water, with a result that was as astonishing to me as it was beneficial to the patient, so that now in all cases of nervous diseases under my charge in which there is an excess of uric acid in the blood, I use the Buffalo Lithia Water in large quantities. By this I mean that I do not have the patient drink merely a tumbler or two in the course of the day, but that I flood him, so to speak, with the water, making him drink a gallon, or even more, in the twenty-four hours. By this course the urine after a few days ceases to deposit uric acid crystals on standing, the morbid irritability of the patient disappears, the tongue becomes clean, the wandering pains in the head are abolished, and the system is rendered much more amenable to the special treatment which may be necessary for the cure of the disease from which the patient suffers.

I have tried carbonate of lithia dissolved in water in various proportions, but it certainly does not, in cases to which I refer, have the same effect as Buffalo Lithia Water.

Washington, D. C., January 25, 1892.

UNIVERSITY OF MARYLAND—SCHOOL OF MEDICINE
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DR. WM. T. HOWARD,

Professor of Diseases of Women and Children in the University of Maryland, says:

After comparing the water of SPRING NO. 1 with that of a very celebrated water

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All the Affections Peculiar to Women

that are remediable at all by mineral waters. In short, were I called upon to state from what Mineral Waters I have seen the greatest and most unmistakable amount of good accrue in the largest number of cases in a general way, I would unhesitatingly say the Buffalo Springs, in Mecklenburg County, Virginia."

Water in cases of one dozen half-gallon bottles, $5.00, f. o. b. here. For sale by all first-class druggists.

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J. LINDSAY PORTEOUS,
M. D., F. R. C. S.—*Ed.*

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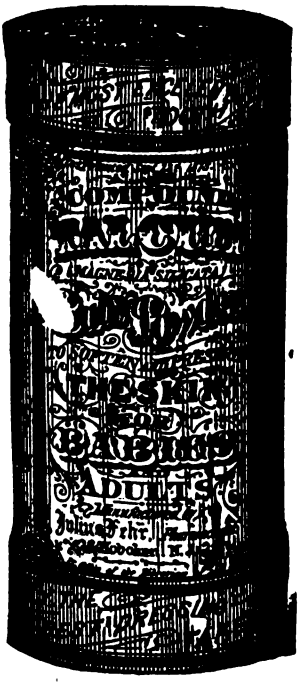

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